

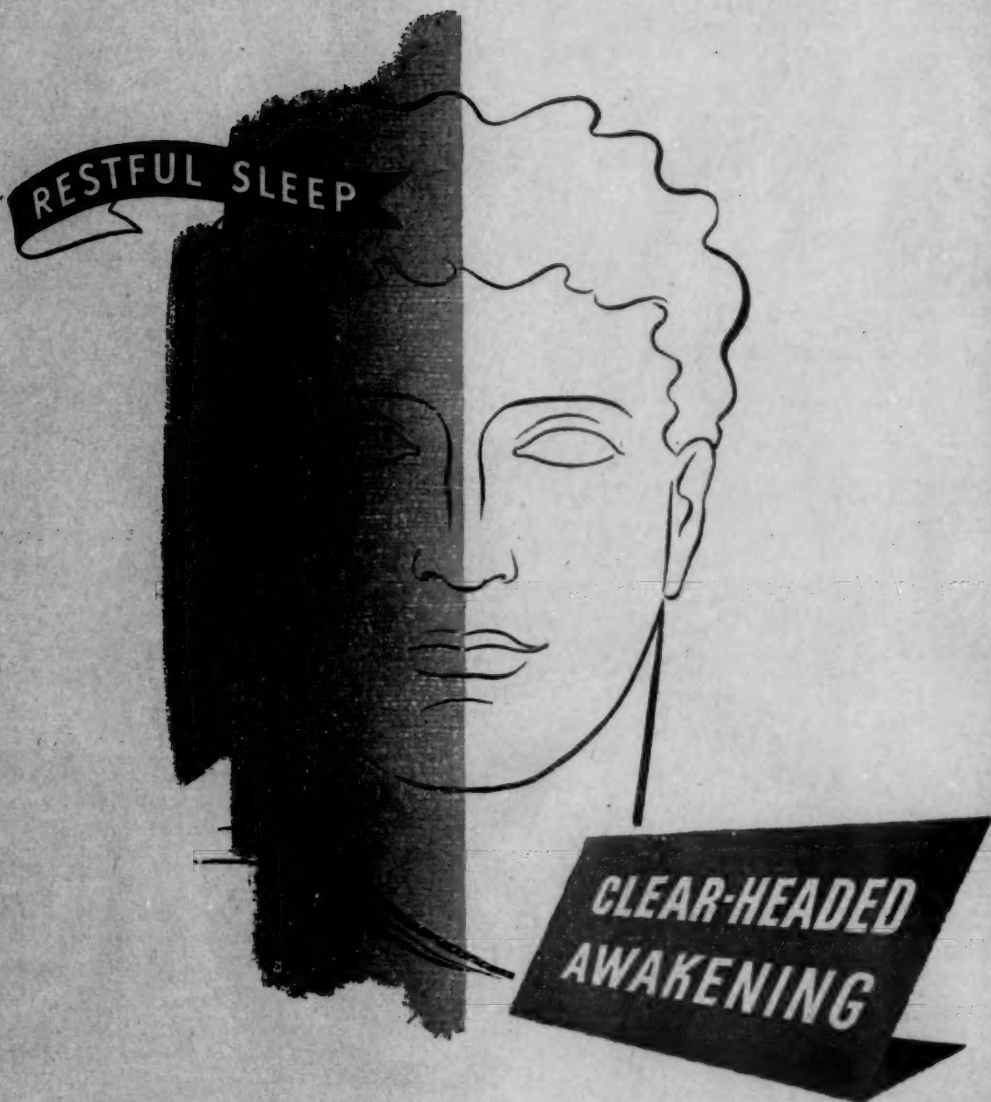
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# SYMPTOMATOLOGY AND MANAGEMENT OF ACUTE GRIEF<sup>1</sup>

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## INTRODUCTION

At first glance, acute grief would not seem to be a medical or psychiatric disorder in the strict sense of the word but rather a normal reaction to a distressing situation. However, the understanding of reactions to traumatic experiences whether or not they represent clear-cut neuroses has become of ever-increasing importance to the psychiatrist. Bereavement or the sudden cessation of social interaction seems to be of special interest because it is often cited among the alleged psychogenic factors in psychosomatic disorders. The enormous increase in grief reactions due to war casualties, furthermore, demands an evaluation of their probable effect on the mental and physical health of our population.

The points to be made in this paper are as follows:

1. Acute grief is a definite syndrome with psychological and somatic symptomatology.
2. This syndrome may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent.
3. In place of the typical syndrome there may appear distorted pictures, each of which represents one special aspect of the grief syndrome.
4. By appropriate techniques these distorted pictures can be successfully transformed into a normal grief reaction with resolution.

Our observations comprise 101 patients. Included are (1) psychoneurotic patients who lost a relative during the course of treatment, (2) relatives of patients who died in the hospital, (3) bereaved disaster victims (Cocoanut Grove Fire) and their close relatives, (4) relatives of members of the armed forces.

<sup>1</sup> Read at the Centenary Meeting of The American Psychiatric Association, Philadelphia, Pa., May 15-18, 1944.

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The investigation consisted of a series of psychiatric interviews. Both the timing and the content of the discussions were recorded. These records were subsequently analysed in terms of the symptoms reported and of the changes in mental status observed progressively through a series of interviews. The psychiatrist avoided all suggestions and interpretations until the picture of symptomatology and spontaneous reaction tendencies of the patients had become clear from the records. The somatic complaints offered important leads for objective study. Careful laboratory work on spiograms, g.-i. functions, and metabolic studies are in progress and will be reported separately. At present we wish to present only our psychological observations.

## SYMPTOMATOLOGY OF NORMAL GRIEF

The picture shown by persons in acute grief is remarkably uniform. Common to all is the following syndrome: sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, and an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain. The patient soon learns that these waves of discomfort can be precipitated by visits, by mentioning the deceased, and by receiving sympathy. There is a tendency to avoid the syndrome at any cost, to refuse visits lest they should precipitate the reaction, and to keep deliberately from thought all references to the deceased.

The striking features are (1) the marked tendency to sighing respiration; this respiratory disturbance was most conspicuous when the patient was made to discuss his grief. (2) The complaint about lack of strength and exhaustion is universal and is described as follows: "It is almost impossible to climb up a stairway." "Everything I lift seems so heavy." "The slightest effort makes me feel exhausted." "I can't walk to the corner with-

out feeling exhausted." (3) Digestive symptoms are described as follows: "The food tastes like sand." "I have no appetite at all." "I stuff the food down because I have to eat." "My saliva won't flow." "My abdomen feels hollow." "Everything seems slowed up in my stomach."

The sensorium is generally somewhat altered. There is commonly a slight sense of unreality, a feeling of increased emotional distance from other people (sometimes they appear shadowy or small), and there is intense preoccupation with the image of the deceased. A patient who lost his daughter in the Cocoanut Grove disaster visualized his girl in the telephone booth calling for him and was much troubled by the loudness with which his name was called by her and was so vividly preoccupied with the scene that he became oblivious of his surroundings. A young navy pilot lost a close friend; he remained a vivid part of his imagery, not in terms of a religious survival but in terms of an imaginary companion. He ate with him and talked over problems with him, for instance, discussing with him his plan of joining the Air Corps. Up to the time of the study, six months later, he denied the fact that the boy was no longer with him. Some patients are much concerned about this aspect of their grief reaction because they feel it indicates approaching insanity.

Another strong preoccupation is with feelings of guilt. The bereaved searches the time before the death for evidence of failure to do right by the lost one. He accuses himself of negligence and exaggerates minor omissions. After the fire disaster the central topic of discussion for a young married woman was the fact that her husband died after he left her following a quarrel, and of a young man whose wife died that he fainted too soon to save her.

In addition, there is often disconcerting loss of warmth in relationship to other people, a tendency to respond with irritability and anger, a wish not to be bothered by others at a time when friends and relatives make a special effort to keep up friendly relationships.

These feelings of hostility, surprising and quite inexplicable to the patients, disturbed

them and again were often taken as signs of approaching insanity. Great efforts are made to handle them, and the result is often a formalized, stiff manner of social interaction.

The activity throughout the day of the severely bereaved person shows remarkable changes. There is no retardation of action and speech; quite to the contrary, there is a push of speech, especially when talking about the deceased. There is restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do. There is, however, at the same time, a painful lack of capacity to initiate and maintain organized patterns of activity. What is done is done with lack of zest, as though one were going through the motions. The bereaved clings to the daily routine of prescribed activities; but these activities do not proceed in the automatic, self-sustaining fashion which characterizes normal work but have to be carried on with effort, as though each fragment of the activity became a special task. The bereaved is surprised to find how large a part of his customary activity was done in some meaningful relationship to the deceased and has now lost its significance. Especially the habits of social interaction—meeting friends, making conversation, sharing enterprises with others—seem to have been lost. This loss leads to a strong dependency on anyone who will stimulate the bereaved to activity and serve as the initiating agent.

These five points—(1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of patterns of conduct—seem to be pathognomonic for grief. There may be added a sixth characteristic, shown by patients who border on pathological reactions, which is not so conspicuous as the others but nevertheless often striking enough to color the whole picture. This is the appearance of traits of the deceased in the behavior of the bereaved, especially symptoms shown during the last illness, or behavior which may have been shown at the time of the tragedy. A bereaved person is observed or finds himself walking in the manner of his deceased father. He looks in the mirror and believes that his face

appears just like that of the deceased. He may show a change of interests in the direction of the former activities of the deceased and may start enterprises entirely different from his former pursuits. A wife who lost her husband, an insurance agent, found herself writing to many insurance companies offering her services with somewhat exaggerated schemes. It seemed a regular observation in these patients that the painful preoccupation with the image of the deceased described above was transformed into preoccupation with symptoms or personality traits of the lost person, but now displaced to their own bodies and activities by identification.

#### COURSE OF NORMAL GRIEF REACTIONS

The duration of a grief reaction seems to depend upon the success with which a person does the *grief work*, namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. One of the big obstacles to this work seems to be the fact that many patients try to avoid the intense distress connected with the grief experience and to avoid the expression of emotion necessary for it. The men victims after the Cocoanut Grove fire appeared in the early psychiatric interviews to be in a state of tension with tightened facial musculature, unable to relax for fear they might "break down." It required considerable persuasion to yield to the grief process before they were willing to accept the discomfort of bereavement. One assumed a hostile attitude toward the psychiatrist, refusing to allow any references to the deceased and rather rudely asking him to leave. This attitude remained throughout his stay on the ward, and the prognosis for his condition is not good in the light of other observations. Hostility of this sort was encountered on only occasional visits with the other patients. They became willing to accept the grief process and to embark on a program of dealing in memory with the deceased person. As soon as this became possible there seemed to be a rapid relief of tension and the subsequent interviews were rather animated conversations in which the deceased was idealized and in which mis-

givings about the future adjustment were worked through.

Examples of the psychiatrist's rôle in assisting patients in their readjustment after bereavement are contained in the following case histories. The first shows a very successful readjustment.

A woman, aged 40, lost her husband in the fire. She had a history of good adjustment previously. One child, ten years old. When she heard about her husband's death she was extremely depressed, cried bitterly, did not want to live, and for three days showed a state of utter dejection.

When seen by the psychiatrist, she was glad to have assistance and described her painful preoccupation with memories of her husband and her fear that she might lose her mind. She had a vivid visual image of his presence, picturing him as going to work in the morning and herself as wondering whether he would return in the evening, whether she could stand his not returning, then, describing to herself how he does return, plays with the dog, receives his child, and gradually tried to accept the fact that he is not there any more. It was only after ten days that she succeeded in accepting his loss and then only after having described in detail the remarkable qualities of her husband, the tragedy of his having to stop his activities at the pinnacle of his success, and his deep devotion to her.

In the subsequent interviews she explained with some distress that she had become very much attached to the examiner and that she waited for the hour of his coming. This reaction she considered disloyal to her husband but at the same time she could accept the fact that it was a hopeful sign of her ability to fill the gap he had left in her life. She then showed a marked drive for activity, making plans for supporting herself and her little girl, mapping out the preliminary steps for resuming her old profession as secretary, and making efforts to secure help from the occupational therapy department in reviewing her knowledge of French.

Her convalescence, both emotional and somatic, progressed smoothly, and she made a good adjustment immediately on her return home.

A man of 52, successful in business, lost his wife, with whom he had lived in happy marriage. The information given him about his wife's death confirmed his suspicions of several days. He responded with a severe grief reaction, with which he was unable to cope. He did not want to see visitors, was ashamed of breaking down, and asked to be permitted to stay in the hospital on the psychiatric service, when his physical condition would have permitted his discharge, because he wanted further assistance. Any mention of his wife produced a severe wave of depressive reaction, but with psychiatric assistance he gradually became willing to go through this painful process, and after three days on the psychiatric service he seemed well enough to go home.

He showed a high rate of verbal activity, was restless, needed to be occupied continually, and felt

that the experience had whipped him into a state of restless overactivity.

As soon as he returned home he took an active part in his business, assuming a post in which he had a great many telephone calls. He also took over the rôle of amateur psychiatrist to another bereaved person, spending time with him and comforting him for his loss. In his eagerness to start anew, he developed a plan to sell all his former holdings, including his house, his furniture, and giving away anything which could remind him of his wife. Only after considerable discussion was he able to see that this would mean avoiding immediate grief at the price of an act of poor judgment. Again he had to be encouraged to deal with his grief reactions in a more direct manner. He has made a good adjustment.

With eight to ten interviews in which the psychiatrist shares the grief work, and with a period of from four to six weeks, it was ordinarily possible to settle an uncomplicated and undistorted grief reaction. This was the case in all but one of the 13 Coconut Grove fire victims.

#### MORBID GRIEF REACTIONS

Morbid grief reactions represent distortions of normal grief. The conditions mentioned here were transformed into "normal reactions" and then found their resolution.

a. *Delay of Reaction.*—The most striking and most frequent reaction of this sort is *delay* or *postponement*. If the bereavement occurs at a time when the patient is confronted with important tasks and when there is necessity for maintaining the morale of others, he may show little or no reaction for weeks or even much longer. A brief delay is described in the following example.

A girl of 17 lost both parents and her boy friend in the fire and was herself burned severely, with marked involvement of the lungs. Throughout her stay in the hospital her attitude was that of cheerful acceptance without any sign of adequate distress. When she was discharged at the end of three weeks she appeared cheerful, talked rapidly, with a considerable flow of ideas, seemed eager to return home and to assume the rôle of parent for her two younger siblings. Except for slight feelings of "loneliness" she complained of no distress.

This period of griefless acceptance continued for the next two months, even when the household was dispersed and her younger siblings were placed in other homes. Not until the end of the tenth week did she begin to show a true state of grief with marked feelings of depression, intestinal emptiness, tightness in her throat, frequent crying, and vivid preoccupation with her deceased parents.

That this delay may involve years became obvious first by the fact that patients in acute bereavement about a recent death may soon upon exploration be found preoccupied with grief about a person who died many years ago. In this manner a woman of 38, whose mother had died recently and who had responded to the mother's death with a surprisingly severe reaction, was found to be but mildly concerned with her mother's death but deeply engrossed with unhappy and perplexing fantasies concerning the death of her brother, who died twenty years ago under dramatic circumstances from metastasizing carcinoma after amputation of his arm had been postponed too long. The discovery that a former unresolved grief reaction may be precipitated in the course of the discussion of another recent event was soon demonstrated in psychiatric interviews by patients who showed all the traits of a true grief reaction when the topic of a former loss arose.

The precipitating factor for the delayed reaction may be a deliberate recall of circumstances surrounding the death or may be a spontaneous occurrence in the patient's life. A peculiar form of this is the circumstance that a patient develops the grief reaction at the time when he himself is as old as the person who died. For instance, a railroad worker, aged 42, appeared in the psychiatric clinic with a picture which was undoubtedly a grief reaction for which he had no explanation. It turned out that when he was 22, his mother, then 42, had committed suicide.

b. *Distorted Reactions.*—The delayed reactions may occur after an interval which was not marked by any abnormal behavior or distress, but in which there developed an *alteration* in the patient's *conduct* perhaps not conspicuous or serious enough to lead him to a psychiatrist. These alterations may be considered as the surface manifestations of an unresolved grief reaction, which may respond to fairly simple and quick psychiatric management if recognized. They may be classified as follows: (1) *overactivity without a sense of loss*, rather with a sense of wellbeing and zest, the activities being of an expansive and adventurous nature and bearing semblance to the activities formerly carried out by the deceased, as described

above; (2) *the acquisition of symptoms belonging to the last illness of the deceased*. This type of patient appears in medical clinics and is often labelled hypochondriasis or hysteria. To what extent actual alterations of physiological functions occur under these circumstances will have to be a field of further careful inquiry. I owe to Dr. Chester Jones a report about a patient whose electrocardiogram showed a definite change during a period of three weeks, which started two weeks after the time her father died of heart disease.

While this sort of symptom formation "by identification" may still be considered as conversion symptoms such as we know from hysteria, there is another type of disorder doubtlessly presenting (3) a recognized *medical disease*, namely, a group of psychosomatic conditions, predominantly ulcerative colitis, rheumatoid arthritis, and asthma. Extensive studies in ulcerative colitis have produced evidence that 33 out of 41 patients with ulcerative colitis developed their disease in close time relationship to the loss of an important person. Indeed, it was this observation which first gave the impetus for the present detailed study of grief. Two of the patients developed bloody diarrhea at funerals. In the others it developed within a few weeks after the loss. The course of the ulcerative colitis was strikingly benefited when this grief reaction was resolved by psychiatric technique.

At the level of social adjustment there often occurs a conspicuous (4) *alteration in relationship to friends and relatives*. The patient feels irritable, does not want to be bothered, avoids former social activities, and is afraid he might antagonize his friends by his lack of interest and his critical attitudes. Progressive social isolation follows, and the patient needs considerable encouragement in re-establishing his social relationships.

While overflowing hostility appears to be spread out over all relationships, it may also occur as (5) *furious hostility against specific persons*; the doctor or the surgeon are accused bitterly for neglect of duty and the patient may assume that foul play has led to the death. It is characteristic that while patients talk a good deal about their suspicions and their bitter feelings, they are not

likely to take any action against the accused, as a truly paranoid person might do.

(6) Many bereaved persons struggled with much effort against these feelings of hostility, which to them seem absurd, representing a vicious change in their characters and to be hidden as much as possible. Some patients succeed in hiding their hostility but become wooden and formal, with affectivity and conduct *resembling schizophrenic pictures*. A typical report is this, "I go through all the motions of living. I look after my children. I do my errands. I go to social functions, but it is like being in a play; it doesn't really concern me. I can't have any warm feelings. If I were to have any feelings at all I would be angry with everybody." This patient's reaction to therapy was characterized by growing hostility against the therapist, and it required considerable skill to make her continue interviews in spite of the disconcerting hostility which she had been fighting so much. The absence of emotional display in this patient's face and actions was quite striking. Her face had a mask-like appearance, her movements were formal, stilted, robot-like, without the fine play of emotional expression.

(7) Closely related to this picture is a *lasting loss of patterns of social interaction*. The patient cannot initiate any activity, is full of eagerness to be active—restless, can't sleep—but throughout the day he will not start any activity unless "primed" by somebody else. He will be grateful at sharing activities with others but will not be able to make up his mind to do anything alone. The picture is one of lack of decision and initiative. Organized activities along social lines occur only if a friend takes the patient along and shares the activity with him. Nothing seems to promise reward; only the ordinary activities of the day are carried on, and these in a routine manner, falling apart into small steps, each of which has to be carried out with much effort and without zest.

(8) There is, in addition, a picture in which a patient is active but in which most of his activities attain a coloring which is *detrimental to his own social and economic existence*. Such patients with uncalled for generosity, give away their belongings, are easily lured into foolish economic dealings,

lose their friends and professional standing by a series of "stupid acts," and find themselves finally without family, friends, social status or money. This protracted self-punitive behavior seems to take place without any awareness of excessive feelings of guilt. It is a particularly distressing grief picture because it is likely to hurt other members of the family and drag down friends and business associates.

(9) This leads finally to the picture in which the grief reaction takes the form of a straight *agitated depression* with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment. Such patients may be dangerously suicidal.

A young man aged 32 had received only minor burns and left the hospital apparently well on the road to recovery just before the psychiatric survey of the disaster victims took place. On the fifth day he had learned that his wife had died. He seemed somewhat relieved of his worry about her fate; impressed the surgeon as being unusually well-controlled during the following short period of his stay in the hospital.

On January 1st he was returned to the hospital by his family. Shortly after his return home he had become restless, did not want to stay at home, had taken a trip to relatives trying to find rest, had not succeeded, and had returned home in a state of marked agitation, appearing preoccupied, frightened, and unable to concentrate on any organized activity. The mental status presented a somewhat unusual picture. He was restless, could not sit still or participate in any activity on the ward. He would try to read, drop it after a few minutes, or try to play pingpong, give it up after a short time. He would try to start conversations, break them off abruptly, and then fall into repeated murmured utterances: "Nobody can help me. When is it going to happen? I am doomed, am I not?" With great effort it was possible to establish enough rapport to carry on interviews. He complained about his feeling of extreme tension, inability to breathe, generalized weakness and exhaustion, and his frantic fear that something terrible was going to happen. "I'm destined to live in insanity or I must die. I know that it is God's will. I have this awful feeling of guilt." With intense morbid guilt feelings, he reviewed incessantly the events of the fire. His wife had stayed behind. When he tried to pull her out, he had fainted and was shoved out by the crowd. She was burned while he was saved. "I should have saved her or I should have died too." He complained about being filled with an incredible violence and did not know what to do about it. The rapport established with him lasted for only brief periods of time. He then would fall back into his state of intense agitation and muttering. He slept poorly even with large sedation. In the course of

four days he became somewhat more composed, had longer periods of contact with the psychiatrist, and seemed to feel that he was being understood and might be able to cope with his morbid feelings of guilt and violent impulses. On the sixth day of his hospital stay, however, after skillfully distracting the attention of his special nurse, he jumped through a closed window to a violent death.

If the patient is not conspicuously suicidal, it may nevertheless be true that he has a strong desire for painful experiences, and such patients are likely to desire shock treatment of some sort, which they picture as a cruel experience, such as electrocution might be.

A 28-year-old woman, whose 20 months-old son was accidentally smothered developed a state of severe agitated depression with self-accusation, inability to enjoy anything, hopelessness about the future, overflow of hostility against the husband and his parents, also with excessive hostility against the psychiatrist. She insisted upon electric-shock treatment and was finally referred to another physician who treated her. She responded to the shock treatments very well and felt relieved of her sense of guilt.

It is remarkable that agitated depressions of this sort represent only a small fraction of the pictures of grief in our series.

#### PROGNOSTIC EVALUATION

Our observations indicate that to a certain extent the type and severity of the grief reaction can be predicted. Patients with obsessive personality make-up and with a history of former depressions are likely to develop an agitated depression. Severe reactions seem to occur in mothers who have lost young children. The intensity of interaction with the deceased before his death seems to be significant. It is important to realize that such interaction does not have to be of the affectionate type; on the contrary, the death of a person who invited much hostility, especially hostility which could not well be expressed because of his status and claim to loyalty, may be followed by a severe grief reaction in which hostile impulses are the most conspicuous feature. Not infrequently the person who passed away represented a key person in a social system, his death being followed by disintegration of this social system and by a profound alteration of the living and social conditions for the bereaved. In such cases readjustment

presents a severe task quite apart from the reaction to the loss incurred. All these factors seem to be more important than a tendency to react with neurotic symptoms in previous life. In this way the most conspicuous forms of morbid identification were found in persons who had no former history of a tendency to psychoneurotic reactions.

#### MANAGEMENT

Proper psychiatric management of grief reactions may prevent prolonged and serious alterations in the patient's social adjustment, as well as potential medical disease. The essential task facing the psychiatrist is that of sharing the patient's grief work, namely, his efforts at extricating himself from the bondage to the deceased and at finding new patterns of rewarding interaction. It is of the greatest importance to notice that not only over-reaction but under-reaction of the bereaved must be given attention, because delayed responses may occur at unpredictable moments and the dangerous distortions of the grief reaction, not conspicuous at first, be quite destructive later and these may be prevented.

Religious agencies have led in dealing with the bereaved. They have provided comfort by giving the backing of dogma to the patient's wish for continued interaction with the deceased, have developed rituals which maintain the patient's interaction with others, and have counteracted the morbid guilt feelings of the patient by Divine Grace and by promising an opportunity for "making up" to the deceased at the time of a later reunion. While these measures have helped countless mourners, comfort alone does not provide adequate assistance in the patient's grief work. He has to accept the pain of the bereavement. He has to review his relationships with the deceased, and has to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalize his feelings of guilt, and he will have to find persons

around him whom he can use as "primers" for the acquisition of new patterns of conduct. All this can be done in eight to ten interviews.

Special techniques are needed if hostility is the most marked feature of the grief reaction. The hostility may be directed against the psychiatrist, and the patient will have such guilt over his hostility that he will avoid further interviews. The help of a social worker or a minister, or if these are not available, a member of the family, to urge the patient to continue coming to see the psychiatrist may be indispensable. If the tension and the depressive features are too great, a combination of benzedrine sulphate, 5-10 mgm. b.i.d., and sodium amytal, 3 gr. before retiring, may be useful in first reducing emotional distress to a tolerable degree. Severe agitated depressive reactions may defy all efforts of psychotherapy and may respond well to shock treatment.

Since it is obvious that not all bereaved persons, especially those suffering because of war casualties, can have the benefit of expert psychiatric help, much of this knowledge will have to be passed on to auxiliary workers. Social workers and ministers will have to be on the look-out for the more ominous pictures, referring these to the psychiatrist while assisting the more normal reactions themselves.

#### ANTICIPATORY GRIEF REACTIONS

While our studies were at first limited to reactions to actual death, it must be understood that grief reactions are just one form of separation reactions. Separation by death is characterized by its irreversibility and finality. Separation may, of course, occur for other reasons. We were at first surprised to find genuine grief reactions in patients who had not experienced a bereavement but who had experienced separation, for instance with the departure of a member of the family into the armed forces. Separation in this case is not due to death but is under the threat of death. A common picture hitherto not appreciated is a syndrome which we have designated *anticipatory grief*. The patient is so concerned with her adjustment after the potential death of father or son that she goes through all the phases of grief—depres-

sion, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it. While this reaction may well form a safeguard against the impact of a sudden death notice, it can turn out to be of a disadvantage at the occasion of reunion. Several instances of this sort came to our attention when a soldier just returned from the battlefield complained that his wife did not love him anymore and demanded immediate divorce. In such situations apparently the grief work had been done so effectively that the patient has emancipated herself and the readjustment must now be directed towards new interaction. It is important to know this because many family disasters of this sort may be avoided through prophylactic measures.

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Many of the observations are, of course, not entirely new. Delayed reactions were described by Helene Deutsch(1). Shock treatment in agitated depressions due to bereavement has recently been advocated by Myerson(2). Morbid identification has been stressed at many points in the psychoanalytic literature and recently by H. A. Murray(3). The relation of mourning and depressive psychoses has been discussed by Freud(4), Melanie Klein(5), and Abraham(6). Bereavement reactions in war time were discussed by Wilson(7). The reactions after the Coconut

Grove fire were described in some detail in a chapter of the monograph on this civilian disaster(8). The effect of wartime separations was reported by Rosenbaum(9). The incidence of grief reactions among the psychogenic factors in asthma and rheumatoid arthritis has been mentioned by Cobb, *et al.*(10, 11).

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## THE SOCIAL ANXIETY NEUROSIS—ITS POSSIBLE RELATIONSHIP TO SCHIZOPHRENIA<sup>1</sup>

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The human being is immersed in a sea of stimulation. For the diverse stimuli which pour in on him he has selective receptors and is thus both involuntarily and selectively stimulated. The chemical and physical changes thus produced are elaborated by neuron linkings into sensations and perceptions and are in part stored up as experiential and motivating memories, but mostly flow over or are converted into motions of all kinds, involving both the voluntary and involuntary muscles of the body. An *effect* of these motions is an *affect* which reaches consciousness as a feeling-tone which is unified under the name "excitement." Moreover, the more *meaningful* a stimulation is, the more it creates excitement. This excitement may be pleasurable and thus be a sought-for goal of activity, and in fact a good deal of human pleasure-seeking is for excitement, which may even be akin to the terrible or horrifying. Excitement may be distinctly unpleasant and wholly terrifying and take the form of visceral activity which smashes into consciousness and is experienced as an impaired functioning of the organism. Thus it is pleasurable to feel some acceleration of the pulse, but it becomes unpleasant when the pounding of the heart against the ribs is too persistent and the sense of pulsating throughout the whole organism persists for a considerable period of time. It is pleasant to feel some flushing in the presence of others; but to flush deeply and continuously is very disconcerting. It is a joy to feel more alive, so to speak, as a result of the mingling with a crowd; but to feel jittery, tremulous and to become viscerally conscious is terrifying.

It is a remarkable fact, one not yet sufficiently studied, that the viscera operate under the influence of a marvellous silencing mech-

anism. The heart is a sturdy pump which sends a current of fluid swishing to the remotest interstices of the body, yet ordinarily we know nothing at all of this, so far as our consciousness is concerned. If the silencing mechanism is impaired, then we become heart conscious, its pounding and its pulsation distract us from attention to the outer world, and, because of our knowledge or information, faulty or otherwise, of heart disease, we fear. The lungs are a pair of bellows which inflate to receive air and deflate to expel the waste products of metabolism. Partly voluntary and partly unconscious as this function of respiration is, ordinarily it goes on automatically. But if we become aware of our breathing, and the movements of our chests and diaphragms obtrude into consciousness obsessively and continuously, anxiety appears. So the overreaction of any part of the organism to stimulation and to excitement breeds anxiety and, in large measure, what has been termed the "anxiety neurosis" is first an over-response of the organism to stimulation; second, as a result of this, or accompanying it, a disappearance of the silencing mechanism so that the functions of the viscera come to attention; third, a mal-functioning of the viscera so that the heart-beat becomes too rapid, the bladder urgently demands too frequent emptying, the gastro-intestinal tract, one of the prime instruments of the manifestations of emotion and excitement, especially of fear and anxiety, manifests its disordered functioning by nausea, vomiting, diarrhoea or spastic constipation.

What is here defined as the social neurosis is a variety of the anxiety neurosis, because it is the adverse, apprehensive reaction to the most exciting objects of our environment, namely, our fellows. It is therefore one of the commonest forms of social mal-adjustment, though the damage is to the individual himself and not to society. We may attach meaning to trees, flowers, to houses and cathedrals, and to the manifold

<sup>1</sup> Read at the one hundredth annual meeting of The American Psychiatric Association, Philadelphia, Pa., May 15-18, 1944.

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of nature, but the deepest and most emotion-laden contacts we have are with individuals or groups. The social neurosis, therefore, is manifested by the same kinds of psychosomatic disturbances as those which are found in all of the anxiety states, but these are especially related in their genesis and evolution to our social life, to the meeting of personalities, the conflicts of will, the exhibition of superiority and inferiority, to communication and its ebb and flow, to whatever happens whenever and wherever men meet and mingle. It may come with the social contact and so has been called a contact neurosis, but it also comes with anticipation of contact and mingling, and finally the visceral disturbance comes to occupy the center of attention and it is this which the sufferer brings to the physician as his presenting complaint.

It is not sufficient to say that man is naturally a gregarious animal, living in herds and building up binding customs and sanctions which apply from the beginning of life to the end in an inexorable way. There is an appetite for, and a facility to enter into, social relationships which varies enormously amongst the members of any and all communities and which is quite definitely constitutional in that there is ease and facility or the reverse from infancy to old age. So there are those who from the earliest periods of their lives love the society of others, are interested with a keen and insatiable appetite in the doings and the sayings of other people; who are not burdened with harmful self-consciousness but feel at ease under the scrutiny which invariably takes place when human beings meet with one another; who bear without any awareness of difficulty that constant appraisal and flow of opinion which, like a whirlpool, involves men wherever they meet, greet and live with each other.

All their lives, these fortunate people communicate with others freely and without too much sense of let and hindrance. They reveal as they wish to and conceal adequately, since a successful social existence consists, in large measure at least, of being able to reveal oneself in a desirable, interesting and socially-approved fashion and, as importantly, if perhaps less consciously, of the capacity to conceal what goes on within oneself in social relationships—the forbidden, the inadequate,

the inappropriate, the unapproved and the disapproved, feelings and thoughts which constantly surge within us. Mankind has built up greeting complexes of word and action, by which the preliminary sizing-up, which is to some extent hostile and apprehensive, is softened into courtesy and cordiality. The "How do you do, how is your health?", the shaking of hands and bowing, all these are propitiatory and conciliatory, and serve to break the ice so that there may be a mutual entrance into safe, pleasant and efficient social relationships. The sizing-up and feeling-out process goes on as one talks about the weather, avoids the controversial, and gives the impression of ease and graciousness. So, to put the matter serially, when people meet, there is first a sizing-up and a scrutinizing process, second a quick and, if skillful, successful breaking-down of barriers, or, third, the building-up of barriers if one finds that the vis-a-vis or the group is unfriendly, cold, over-critical, etc.

*The ability to stand the social scrutiny, to enter into easy and communicative relationships, the feeling of being secure in that one does not reveal too much and conceals successfully, is greatly impaired in those unfortunate people who suffer from what has been called the social neurosis.* For them, to meet the barrage of other people's eyes, to bear the faces that turn with gaze directed at them, is an ordeal which freezes spontaneity, makes communication halting and painful, seems to lessen productivity of thought, takes away ease and charm and graciousness, and, especially with all these, brings an anxiety which manifests itself in disconcerting general and specific somatic disturbances. The finest examples of what now-a-days is called psychosomatics are to be culled from the ranks of those who suffer from the social neurosis.

In its earlier stages, the syndrome manifests itself mainly in shyness, timidity and self-consciousness. Consciousness of self and self-consciousness are not the same. Awareness spreads from the environment with its multitudinous and changing aspects cognized through the senses and built up into objects of sense and meaning, to consciousness of the sensations experienced in this interchange between the self and the world; then there

takes place the building up of the idea of self, and finally the self in its changing attitudes, plans, projects, and feelings becomes unified into something of an independent nature and becomes an object of study. This transition from outward to inner attention is not necessarily painful and is part of the larger growth of the personality. It may be consistent with a feeling of superiority and self-admiration. To some Selves, the Self may be studied almost as purely objectively as the rest of the world and thus without any disconcerting emotion.

*But consciousness of self easily becomes self-consciousness*, which merely means that the individual becomes painfully aware of himself in his relationship to others and especially he becomes concerned, at first reflexly and finally with all his being, with his worth as compared with that of others, and the attention and attitude of others to him. Their attention to him becomes fraught with emotional responses which soon become disorganizing somatic responses. The self-conscious child naturally flushes; as his sense of self-worth and his understanding of others increases, the flush becomes only occasional. But if he never reaches a phase where self-confidence becomes solidly established, if the reaction to the appraisal of others lacks ease and certainty, then a sort of increasing sensitization takes place, by which the flush appears constantly, becomes a thing noted by the sufferer and others, and finally he gets to fear not only the situation but his own reaction to it. "This," he may be imagined as saying to himself, "is a situation in which I flush and betray myself to the curious, the prying and the derisive eyes of others."

Human beings are specialists in functional and organic visceral pathology, that is, they tend to react adversely with one specific set of organs under circumstances charged with excitement and emotional tension. There is a specialized allergy of visceral malfunction under the psychological circumstances of the excitement of human contact, just as there is such allergy to dust particles, pollen, foreign proteins and so forth. For example, one of the chief avenues of the expression of emotion is the gastrointestinal tract. From its upper end nausea and vomiting and belching may be the most important reactions. Thus

social situations in which self-consciousness occurs may be the signal for nausea and even vomiting; and belching may express the anxiety and dread of the sufferer as he faces or is looked at by his fellow man. The lower end of the gastrointestinal tract may express its disorder by flatus and by diarrhoea or by cramps and pains. Thus the individual becomes haunted with the fear that if he goes into this or that place where he has to meet with groups or individuals, diarrhoea and flatus may take place, and so there evolves a shift of apprehensive attention from the situation to the manifestations and a vicious circle becomes established in which it is feared and anticipated that one will commit the unpardonable social error of expelling wind in the presence of others and of having to make hurried and derisively viewed trips to a toilet.

The urinary system, that system by which the fluid equilibrium between cell and circulation is kept at a constant level, manifests adverse emotion by its disturbances especially because of over-excitement and anxiety. Amongst the common symptoms of the social neurosis is frequency and urgency of urination, which may reach so extreme a stage that the bladder-conscious individual is both fatigued and humiliated. This parasympathetic response is paralleled by another response possibly of sympathetic over-stimulation, wherein it becomes difficult to evacuate the bladder and especially in the presence of others. There are cases where a man's social life is completely disorganized, in so far as his association with other men is concerned, by the fact that he cannot empty his bladder in the presence of others, though he has no difficulty when alone. This at once makes hunting trips, long walks, and any kind of intimate association almost impossible, since sooner or later the male members of a party must urinate in the presence of one another.

The circulatory system is as prolific in its manifestations of self-consciousness and anxiety as the gastrointestinal and genitourinary systems. The sufferer from the social neurosis may feel his heart beat with appalling rapidity, develop faint feelings, and reach the belief that his heart will be damaged, that he will faint, or even die. Not only is the visceral damage the focus of his fears, but

the fact that it may attract adverse attention to himself, that he will give himself away by his bodily disturbance, obtrudes, nay smashes into his consciousness with devastating results. Tremor, profuse sweating, even orgasmic responses take place under the scrutiny, so feared, of others.

To turn to a so-called higher plane of malfunctioning, the ability to communicate easily and successfully, to enter into discussion, to tell stories and to have a line of small talk, to take an effective part in the handball game of conversation, is highly prized, and its lack is felt as a great deficit and a serious handicap. Group and vis-a-vis intercommunication are paralyzed by an obsessive self-consciousness, though often enough the actual disability is less than the affrighted consciousness measures it. "What am I going to say?" breeds an agonizing stage-fright, and the stage of its occurrence may finally become every place where folks meet in social and business relationship.

In a somewhat more evolved phase, the social neurosis shows itself by a dread of offending others, of a compelling necessity to please everybody. "I feel myself impelled to do all the dirty work, to become the servant of everybody, and I hate myself for being such a sucker," is the way one of my patients phrased this retreat into propitiatory sweetness and humility. "I have no guts, I can't say no, I can't stand up for my rights, and, though everybody says they like me, I feel that they despise me and I hate myself," are the words of another sufferer from the social neurosis. And to cap the climax of these quotations, "I'd rather be hurt than to hurt, and this is not my blessed goodness but my damned cowardice."

As some of the cited case histories will, I think, exemplify, there are two further directions of evolution of the social neurosis which are of paramount importance. One is the evolution into the explanatory feeling or belief that people *become adversely affected* by something which emanates from the individual, for example, an odor, usually from the lower end of the gastrointestinal tract and to which they respond by hostile or disgusted attitudes and reactions. This is a familiar mechanism in certain phases of schizophrenia. The second direction of evo-

lution leads to paranoid beliefs that others *are adversely affecting* one not by mere contact but by deliberate motive, and so the rapid heart, the feeling of faintness, the gastrointestinal disturbance become charged with the feeling of being influenced, which again is one of the primary delusional systems of schizophrenia. Furthermore, in the early history of a large proportion of schizophrenics, psychosomatic disturbances in the presence of others or in the face of situations which have become difficult to meet are extremely common, if a careful history is taken with details of the early life of the individual, —what is often termed the neurasthenic beginning.<sup>2</sup>

To link up so common a thing as the social neurosis with schizophrenia is, I realize, a hazardous undertaking. I also realize that I have not adduced statistical proof. Yet, bearing this in mind, *one of the most important polarities seen in schizophrenia may be interpreted in social terms akin to those of the social neurosis*. In the catatonic phases, the extreme passivity, the automatic obedience of Kraepelin, is a yielding to the will of somebody else—the investigator. The resistance which is manifested by negativism is the polarity of manifestation common in the mental diseases and represents a senseless hostility and fear of the examiner. *Passivity and resistance are social reactions*. They disappear when the individual is not under scrutiny. They also lessen in incidence when hospital conditions are improved. The incomplete handshake of dementia praecox, upon which Kraepelin laid so much emphasis, is a defective social reaction, because the same individual who lays a limp hand on yours will handle tools and instruments with quickness and vigor. The aversion of the eyes and face which I have described is also a social reaction, signifying the "fear of others" of schizophrenia.

I cite a few cases out of the large number which have come to my attention. I have selected these particular cases to indicate, or, more conservatively, to hint at, the relationship which seems to me to exist between the

<sup>2</sup> See in this connection Jelliffe on predementia praecox. This is emphasized also by Kraepelin, Bleuler and practically all the writers on schizophrenia, but is not given this particular interpretation.

social anxiety neurosis and grave mental disease, especially various phases of schizophrenia.

CASE 1.—This concerns a young man whose mother is in one of the state hospitals. The history of her case is fundamentally that of a paranoid psychosis. She was always secretive, quiet, non-communicative, and later developed definite ideas of persecution and reference. Throughout the long period of her hospitalization and up to the present time, there has been little of real dementia, but there has been evasiveness, some incoherence of speech, constant tendency to misinterpret situations, and a swing from passivity to resistance, both being without any apparent and understandable reason.

The symptom complex of her son can naturally be divided into two main headings of groups of symptoms which seem to me to show an evolving relationship to each other. From the earliest days he has had extreme self-consciousness, with an intolerable sense of discomfort, inability to communicate, and vasovisceral commotion, *in the presence of others*. These have extended into almost every relationship and include the inability to mic-turate in the presence of others. The bodily and mental disturbance in the presence of others is the basis of an "anticipation anxiety," marked social timidity, severe hypochondriacal phases, which show as a very difficult sexual life starting with masturbation, but ending up with some degree of success, since he has married and is the father of a child. His intense self-consciousness is summarized by his statement, "I have to carry myself on my shoulders all the time. I am my own Old Man of the Mountains."

The second group of symptoms relates to certain paranoid reactions with ideas of reference which have appeared transiently on various occasions. When he first came to my office in 1940, he gave an account of his feeling in the presence of a former supervisor in the place where he was employed. When he met this man, he would feel entirely dumb and numb. He had a sense of being powerless in the face of this dominant personality. He had a feeling that this man had some influence on him, and on several occasions he became hostile to him, expressing ideas of reference and persecution. Because of this reaction he left his employment and obtained a position in the post-office. He got along fairly well so long as he did not work in the presence of others, but when he had to do work which brought him into public view, the sense of being scrutinized overpowered him and, from time to time, he developed the idea that people who happened to be laughing were laughing at him, people who smiled, as he thought, sarcastically, and whispered to somebody else, were making remarks of sarcastic and derogatory nature about him. The feeling of reference was very strong, although his critical intelligence and judgment told him that he must be mistaken. From time to time he would improve. The feeling of self-consciousness and of bodily reaction of an adverse type, especially a very conspicuous flushing and sweating

would become less. This was particularly true shortly after he married, but later the condition grew worse. He has become quite pessimistic and hopeless. He has been unable to carry on his job consecutively and each time he has to re-enter his place of employment he finds more and more difficulty and is commencing to show more often and more vividly the feeling of reference and to some extent the idea of persecution.

CASE 2.—This is a little girl of 20, single, who has been a clerk. The family history is declared to be negative. From her earliest days she suffered from an exceeding shyness and avoided social contacts. This was especially marked throughout her grammar and high-school career. For example, she could not get up in class and recite. She would stutter and flush and generally manifest marked anticipation anxiety reactions. When she was younger, she was quite stout. This was believed to be the basis of her feeling of inferiority, or "inferiority complex," as it was called. She came under the care of an endocrinologist who reduced her weight very successfully and the treatment was terminated with attainment of a very attractive figure. The endocrinologist notes this: "The predominant attitude, as far as her tendency to depression was concerned, was motivated by her lack of faith in mankind—according to her words. Another statement she often made was, 'People are awful.'" Despite the fact that she had attained at least average good looks, the situation so far as her self-consciousness and physical reverberations thereto was not improved. She took a civil service examination for meteorology. At the end of a week, she had to give up because she became greatly disturbed by her enforced intimacy with a group of girls and, as part of the fear, expelled gas per rectum. The situation became intolerable to her and she gave up her desirable job and then came under my observation and care.

She states that during puberty, she felt a reverberating anguish when her developing body evoked male scrutiny. She cannot face people without feeling marked internal commotion. *This social anxiety neurosis phase, however, has become associated with delusions.* She now believes that gas of a disgusting odor leaves her body per rectum and offends others, as a result of which they avoid her. She knows this because of the faces they make, the sarcastic remarks that she hears, all of which are of the familiar misinterpretation pattern. She states that she does not smell the odor herself and she knows that she has been told by her friends, family and physicians that no odor is present and that no odor could possibly be present, yet she is sure that this odor does come because of the reactions of others to her. In other words, the fear of the social neurosis has been transformed, so it seems to me, into the delusion of reference. When the matter of inferiority feeling was discussed with her, she stated that she does not feel inferior, that in fact, she has an egotistic notion of her own ability. As the case has been followed, a further evolution has taken place. She now makes the statement that people make remarks about her, that she must be

a bad girl morally, because of her disgusting odor. She gives no evidence for this beyond the misinterpretation of words and phrases which she accidentally hears. That her early self-consciousness had nothing to do with her bodily form is shown by the fact that when the obesity was cured, the social neurosis or anxiety still remained and has gradually taken on a delusional form.

CASES 3, 4, 5.—In the cases of the two sisters and a brother whose clinical histories I now briefly present, the "pseudo-amiability" of social weakness and fear is cogently illustrated. A. is a married woman aged 34, with two children. She started off in life timid and with marked psychosomatic reactions to her fellow man, and finally developed anxiety symptoms of classical configuration in all kinds of situations. She has a tremendous fear of hurting anybody's feelings and this has been a conspicuous factor in her whole life history. She will humble herself in the most complete way. She always avoids standing up for her rights, and though she has many just grievances against her husband for his lack of attention, he has not the slightest idea that he is anything but pleasing to her because she never complains. This is not because, as she puts it, she does not want to complain, but because she has a fear of how he would look and what he would say if he knew she disapproved of his actions. This inability to be self-reliant and self-sustaining has made her the slave of her mother. She rebels inwardly and violently against her own humbleness and lack of backbone. She calls herself a "Mrs. Milquetoast," but is unable even under the most urgent situations to assert herself in the face of another personality.

Her sister is 32 years of age. She dates her illness to a breakdown three years ago, at which time she was very hypochondriacal, exhausted and depressed. During the course of the illness, ties appeared which are not very conspicuous at the present time. With further acquaintance, the following personality traits appear. First her essential timidity shows itself, in that she would rather be hurt than hurt anybody. She has never been able to become aggressive and she is thrown into endless inner self-reproach because of "my lack of backbone and my contempt for myself." She often makes up her mind to assert herself, but she never can. She has a shuddering fear of quarrels and of facing angry or hurt people. She has a friend who calls her each night and talks for one-half hour over the telephone, to her great weariness and the frenzied disgust of her husband. Yet she has never been able to shorten the conversation, or to express her utter boredom. "I 'yes' her to death, I am as sweet as sugar and all the time I want to scream, 'Shut up, you damn fool.'" She has always been afraid to make decisions, though when on occasion she has been forced to do so, she has been right in a reasonable proportion of cases. Throughout her life, in the presence of others, and when any social situation of any consequence was to be met, there were gastrointestinal disturbances, with nausea and occasional vomiting.

The brother of the above two patients is 33 and single. He has always been of a timid and retiring nature, requiring psychiatric attention early in his life. The timidity was especially marked in relation to going to school, though he did well in his studies. He played in no rough sports and feared crowds. While he now has anxiety in many directions, the main fear relates to meeting women and entering into social and sexual relationships with them. The anticipatory reactions are especially marked if he makes a date. Sleep disappears and gastrointestinal disorder always appears. Consequently he can only make a date on the day in which it is to be fulfilled, for otherwise the anticipation will "wreck" him during the interim. Sexually, he is only partly potent. He no longer fears crowds, but in addition to his difficulty in relationship to women he is unable to solicit business from strangers unless they come to his shop.

In his case, the anxiety reactions have their focus in certain specific social situations, though there is a general timidity and anxiety as well.

It has long been known that the mental diseases of siblings tend to be alike, and in general express a similar psychopathology, though often with marked variation in age of onset and severity of involvement. For whatever it may be worth, I mention, to save space, a family of five siblings, three of whom have completely developed schizophrenic states, which started with social timidity, psychosomatic disorder, and finally delusions of reference and of influence appeared which in turn laid the basis of catatonic states. I lay great stress upon the delusion of influence, for I believe it is only a step from the stage of being adversely affected by *Others* to the delusion that the *Others* are maliciously or for benevolent purposes, powerfully and directly bringing about the disturbance. The other two siblings have remained at the stage of social anxiety and unease, cannot meet *Others* on equal terms, and become "frozen" in thought processes and especially in communication in most phases of social relationships, though they quite eloquently describe their anguish to the sympathetic physician, *i.e.*, when there is no fear of the *vis-a-vis*.

It seems to me quite possible that one of the evolutionary developments of human civilization may break down or injure ease of social contact. This is the retreat into privacy which is part of the break-up of primitive social groupings and which takes place when people retreat into separate homes. They thus become shut off from the continuous play of social relationship which exists wherever they are immersed in larger groups. To the child who lives in a single home, thus separated from the rest of the world, except for his parents and his brothers and sisters, all other people become strangers and tend to evoke the fear reaction so con-

genitally embedded in man in the presence of the stranger, and which has been appropriately called xenophobia. The separate home gives opportunity for the growth of individuality, but it is exactly the growth of individuality, the feeling of being a separate and distinct personality which is the basis of the social neurosis. We may be paying a high price for the home and the development of individuality. I believe surely that the increased competitiveness which occurs when the group loses its almost mystic union and becomes broken up into individuals seeking to establish themselves in superior places imposes a huge strain on many individuals. The enhancement of the feeling of individuality which is part of the civilizing process has, I believe, its perils to mental stability.

This does not mean that I accept or believe that there is a "purely psychological" explanation for either the anxiety states, including the social neurosis, or for schizophrenia. It seems perfectly certain that there must be an organic and physiological basis for the ordinary gregarious feeling, just as there is a physiologic organic basis for sex and its manifestations. For man is as fully a gregarious animal as he is a sexual one. It is perfectly possible that there may be hormones and streams of chemicals which have to interact in proper relationships for social ease and social capability to manifest itself. True, no one has as yet isolated mechanisms or chemicals which relate to social feeling and to social ease as well as to social adaptability in general. It is perhaps more likely that social adaptability and social ease are part of a general human fitness made up of many parts, out of which the whole of social activity emerges, and that deficiency in any one of the parts may lead to maladaptation, lack of ease or pleasure in social relationship, and failure of adjustment.

One does not, of course, forget the rôle of early environment, training, teaching, social pressure in general, in bringing about social normality or successful social living. It is conceivable that the social demand, the competitiveness of our lives, the remorseless pressure which seeks to render similar the reactions of all human beings, may be too much for some individuals who conceivably would do well in a society of some other nature. Thus the claim has been made that

in Communist Russia, certain of the mental diseases are on the decline, because competitiveness has lessened. Certainly, the school, the demands of formal education, the constant pressure of competitive evaluation in looks, attributes, capacity to learn, the extraordinary rewards given to the successful child and adult, the adulation of success, all these bring about an atmosphere in which those who are not adept may easily suffer the tortures of the anxiety which I have here described as the social neurosis, and thus start a chain of events which, it seems to me, leads to a chronic state which flares up now and then into active somatic disturbance and social retreat as well as to more profound disorders of the personality structure.

It is impossible, of course, to discuss the social neurosis without considering the "inferiority complex" of Adler. It will be seen at once that what Adler described as the inferiority complex and its working out in the organism may be called "the social neurosis." There is, however, an important point of difference which I wish to emphasize. For Adler the inferiority complex arises from unconscious motivations, organ inferiorities, which work themselves out as the masculine protest and other compensatory processes. He does not view the psychopathology as based on an abnormal reaction to the excitement and stimulation of the social contact and communication. The social neurosis finally evolves into inferiority feeling, but this is a later evolution of the psycho- and visceral pathology. At first there is the inferior reaction; then there is anticipatory anxiety or dread; this evolves into situational reactions of fixed type, frequently psychosomatic, developing, in some cases as I think is true, into actual psychosis; and the feeling of inferiority finally arises as the individual feels himself incapable of coping with situations involving the personalities and confrontations of others.

My description may be called a superficial, non-dynamic interpretation, if one so chooses. It happens that I am very skeptical of the dynamic interpretations of the psychopathological type. I prefer to stick to what is known in the history of these cases, namely: that their viscera misbehave, their thought processes become impaired, their emotional reactions become excessive in the

minglings of the social life. From this there evolve the disastrous vicious circles in which the victim of the social neurosis becomes imprisoned, when the anxiously anticipated event finally moves from the dread future to the dreadful present, and then dread becomes fear, and fear finally become heightened into panic.

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## HEREDITY IN THE FUNCTIONAL PSYCHOSES

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Thus far, four methods have been used for the study of heredity. First in historical order is Sir Francis Galton's family history method, introduced about the middle of the 19th century. Next came Mendel's experimental method which appeared in 1900 and is still in use. The third or combination method arose about 1910 and constitutes an attempt to apply Mendel's laws to family histories. This method has had limited success and is sometimes used today. The fourth is the identical twin method. This approach has only been in vogue during the last two decades; but its statistical series, though small, is quite significant. These four methods will be dealt with in chronological sequence.

Galton's method of studying inheritance is of utmost importance to us, for it is the family history method used in present day psychiatry. The method originated in Galton's fertile imagination in the 1860's. At that time the scientific method was very different from that of today. It was dominated by Charles Darwin, Galton's brilliant cousin. Darwin's method was purely observational. His masterpiece, "The Origin of Species," was a list of observations with his theoretical attempts to explain the observations. The experimental method, as we use it now, was almost non-existent. Influenced by the methods of his time, Galton collected exhaustive observations on the recurrence of selected traits in certain families. He concluded that the traits must be hereditary because they recurred in some families and not in others.

Among his family history studies of natural inheritance, we find a monograph called "Noteworthy Families." In it "The brief biographical notices of 66 noteworthy families . . . are compiled from replies to a circular issued . . . in the spring of 1904 to all living fellows of the Royal Society." Judging by the replies to the circulars, all the family trees studied revealed many men distinguished in the arts and sciences. Eight members of the Darwin family were listed as famous. Galton included himself in this con-

stellation as cousin of Charles Darwin. He concluded from this study that superior intelligence must be inherited because it recurred in generation after generation of the same families. The test of intelligence, of course, was membership in the Royal Society. One wonders how many London slum denizens would have become distinguished in the arts and sciences had they the educational opportunities afforded these sons of the English upper classes.

In his "Hereditary Genius," Galton expanded the family history method. He observed entire populations and then estimated the level of their hereditary intelligence. By this inaccurate method he concluded that the hereditary intelligence of Londoners was inferior to that of English north country folk. His only evidence was that "It is perfectly distressing to me to witness the bedraggled, drugged, mean look of the mass of individuals . . . that one meets in the streets of London. The conditions of their life seem too hard for their constitutions." One wonders whether their 16 hour day and subminimal diet would not be too hard for everyone's "constitution."

The intrinsic fallacy of Galton's observational method is shown in our changing concepts of tuberculosis. Previous to 1882 tuberculosis was believed to be due to heredity. Many families were found in which tuberculosis occurred generation after generation, families were found in which many or all of the siblings had the disease. Such family histories branded these families as having the "scrofulous diathesis" *i.e.*, of being tainted stock which contained tuberculosis, slenderness, fainting spells and rickets. The recurrence of these traits in generation after generation does not prove their hereditary nature. This is the type of evidence we have today for the inheritance of insanity—mere recurrence in the family history. To the modern physician, tuberculosis, slenderness and rickets mean slum environment, not poor heredity. To the modern psychiatrist, generation after generation of insanity means schizoid or manic parents imposing their

unreasonable attitudes on children who warp under the family tensions. These children in turn impress their twisted views on their children and so on down the generations. The process is environmental. The proof is that these repressed traumatic memories can be recovered, if we but listen to our patients.

To return to the original point, in 1882 Koch discovered the tubercle bacillus. The hereditarians refused to surrender. Instead, they advanced the hypothesis that tuberculosis is due to a hereditary susceptibility of the lungs to the bacillus. Suffice to say there has never been a single bit of experimental evidence to show that one human being is more susceptible to a measured dose of tubercle bacilli than another. The hereditarians have discreetly ceased talking of the inheritance of rickets. It used to occur in generation after generation of the same family. It was absent in other families generation after generation.

One or two other examples will suffice to show the fundamental fallacy of Galton's family history method. The first is pellagra. Before Goldberger, it would have been easy to prove that this psychosis was due to the hereditary defects of a tainted family stock. This follows automatically from the fact that the disease occurred in certain families generation after generation and did not occur in other families at all. The fact that lower class families had the disease would support the theory that it was due to tainted stock—for the lower classes were thought to have poor heredity. Conversely, the upper classes seldom showed the disease. This must, of course, be due to their superior heredity. Goldberger's discovery of the p-p factor upset this view, and the discovery of nicotinic acid completely demolished it.

Feeble-mindedness is a third example of the fallacy of the family history method. This condition has long been considered a classic example of the inheritance of a mental disorder. In recent times this concept has largely won support from Goddard's famous study of the Kallikak family. This work opens with an account of Deborah Kallikak, a patient in Goddard's institution at Vineland. Goddard traced Deborah's ancestry through a long line of defectives to the union of Martin Kallikak and a "nameless feeble-

minded girl" in the days of the American Revolution. Martin united himself first with this nameless feeble-minded girl, and started a long row of feeble-minded syphilitics and alcoholics. Then, reforming, he married a girl of Puritan stock, and started a long row of descendants, not a single one of whom was immoral, syphilitic, alcoholic, insane, criminal or feeble-minded. One doubts Goddard's definite diagnosis that this or that post-Revolutionary War ancestor was an idiot, an imbecile or a high-grade moron. Intelligence tests were not devised until much later. Goddard concludes that feeble-mindedness is inherited from tainted stock. He made no attempt to discover whether the supposed feeble-mindedness of an unknown ancestor was due to cerebral agenesis, epidemic meningitis, birth trauma, congenital lues, hypothyroidism, Mongolian idiocy, amaurosis, Schilder's disease, sensory deprivation, encephalitis, congenital hydrocephaly, microcephaly or tuberous sclerosis. It is evident that 13 separate clinical entities cannot be inherited as a single Mendelian character. Again, Goddard labeled certain ancestors syphilitic, but these ancestors died decades before the Wassermann reaction was discovered, and decades before general paresis was discovered to be syphilitic. Having diagnosed syphilis in persons dead for generations, Goddard intimates that the infection is a sign of poor stock. There is no proof that Martin Kallikak is actually the father in question. If the girl were as feeble-minded as indicated, Martin might well be but one of a dozen possible fathers. This one error would invalidate the entire hereditary study. Any family tree investigation must be looked upon as inaccurate, for the more remote the ancestor, the less accurate our knowledge of him must be.

Oftentimes, we "know from observation" that certain human traits are hereditary in various families and races. Take, for example, the question of human height. Ordinarily one takes for granted that Scandinavians are tall and Japanese are short and that this is an inherited character. One takes for granted that tall parents will have tall children and vice versa and that this family character is inherited. However, Franz Boas (1) (1911) found that children born in this

country were taller than children born in Europe of the same parents. Others have shown that Japanese children born in this country of pure blooded Japanese parents are about 1 inch taller than the parents. The children of these children, though still 100 per cent Japanese blood, are in turn about 1 inch taller than their parents and 2 inches taller than their grandparents. The same process holds true for Orthodox Jewish immigrants whose religion prevents outbreeding. Though the heredity is the same, the height increases about 1 inch per generation.

A study made at Harvard University (2,3) disclosed that 1166 undergraduates averaged 1.4 inches taller than their alumni fathers. It will thus be seen that height, which is usually thought to be hereditary, is in fact determined by environment. The precise factor in the environment which determines height is not known, but there is good reason to believe that diet plays the controlling rôle. One can see how the poor dietary habits of short parents might automatically condition the eating habits of the children and make them short as well. This summarizes the underlying error in Galton's statistical method. It cannot, by family observation alone, or by statistics derived therefrom, determine whether a trait is due to heredity or environment, for both are similar in the same family and both are likely to create similarities among the members of that family. It seems advisable to drop this obsolete family history method from our present day psychiatric armamentarium.

We turn now to the second method. In 1866 an obscure Austrian monk named Gregor Mendel gave the world the first accurate method ever developed for the study of heredity. The method lay buried in obscurity until 1900 when it was unearthed simultaneously by Correns of Germany, DeVries of Holland and Von Tschermak of Austria. Gregor Mendel clearly realized that both heredity and environment are variables which influence an individual. He therefore devised experiments in which the environment was kept as constant as he could possibly make it, while he varied the heredity. He concluded that since the environment was constant, variation in the offspring must be due to his experimental variation in the

heredity. It might not be amiss to review some of the experiments of Mendel and his successors.

Mendel's first experiment is shown in Fig. 1. It consisted in mating round and wrinkled garden peas. Fortunately the shape of a green pea depends on a single chromosome. This is the simplest type of inheritance and such single chromosome differences between parents produce monohybrids. Fig. 1 shows the derivation of the famous 3 to 1 Mendelian ratio of three round to one wrinkled.

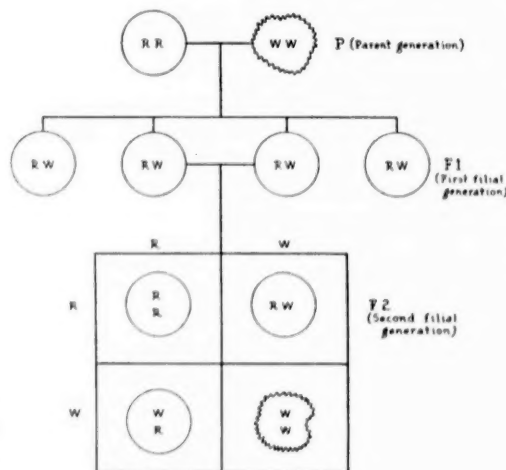


FIG. 1.—Monohybrid. (Parents differ in 1 character.)

In F2 three peas are round. Two of them have wrinkled recessives. These two have the dominant morphology (round) but can transmit wrinkles (W being a recessive gene) to their offspring. The one WW is wrinkled and can only transmit wrinkles to its offspring. The gross morphology of 3 round to 1 wrinkled in F2 is the classical Mendelian 3:1 ratio for a character determined by 1 gene.

This formula, of course, is a general biological law for the behavior of one chromosome inheritance. It will be noticed that several essentials of Mendel's method are concealed in this simple diagram. First, P, the parent generation, consists of pure stock of known genetic constitution. Next, F1, the first filial or experimental generation, consists of siblings all alike. The second filial generation (known as F2) is produced by a brother and sister mating of F1 individuals. The environment has been kept absolutely constant while these mating experiments are being conducted. Under these conditions and

only under these conditions is the characteristic 3 to 1 ratio unearthed. Fig. 2 shows

only 1 of the pair) the animal lived. It may thus be seen that an animal may inherit the

Character	No. dominants	No. recessives	Phenotypic ratios F <sub>2</sub>
Form of seed	5474 smooth	1850 wrinkled	2.96:1
Color of cotyledons	6022 yellow	2001 green	3.01:1
Length of vine	787 tall	277 dwarf	2.84:1
Color pods	428 green	152 yellow	2.82:1

FIG. 2.—Mendel as quoted in Walters' "Genetics."

the size of the series of plants needed to approximate the theoretical ratio. Only when similarly conducted experiments show a 3 to 1 ratio in F<sub>2</sub> can we prove a certain character to be inherited by a 1-chromosome mechanism. Only by the demonstration of the genetic mechanism can Mendel's method be used to prove conclusively that a character is hereditary.

Fig. 3 shows an exception to Mendel's 3 to 1 monohybrid ratio. Cuénot mated

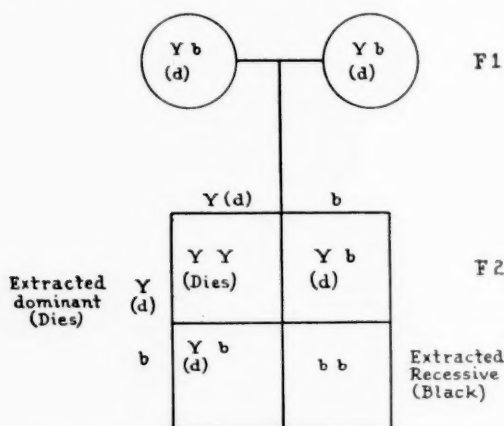


FIG. 3.—This figure shows the effect of a lethal linked dominant in modifying the 3:1 ratio to 2:1. The extracted dominant YY contains two lethal genes and dies in utero.

yellow mice to try to produce pure yellow stock YY. The offspring were 2 yellow which did not breed true to 1 black which did. He rightly inferred that the chromosome containing the yellow gene also had a lethal gene incapable of killing by itself, but capable of killing the embryo when both alleles (paired chromosomes) had the same gene. In other words, when the animal was homozygous for the lethal gene (had the gene in both dominant and recessive chromosome) death was produced. When the animal was heterozygous for the gene (had the gene in

capacity to be born dead and may transmit the character to its offspring. Cuénot proved the point by dissecting the pregnant uteri of his mice and discovering  $\frac{1}{4}$  yellow dead,  $\frac{1}{2}$  yellow alive and  $\frac{1}{4}$  black alive. The latter 2 groups provide the 2 to 1 ratio in the offspring.

Another interesting variation of Mendel's 3:1 monohybrid is a cross between red and ivory snapdragons. The offspring are red if grown in bright light and ivory if grown in dim light. Similarly, the gene for duplicated legs in *Drosophila Melanogaster* (the fruit fly) produces its effect only if the fly is reared at low temperature. In the same fashion, the genes for vestigial wings, bar eyes, etc., produce different effects at different temperatures. These instances reiterate the basic fact that Mendel's laws can only be applied to completely controlled environments constant for all the experimental plants or animals used.

Let us consider the next most complicated genetic mechanism—that in which the parents differ in 2 chromosomes. Fig. 4 shows the basic experiment. A round yellow pea is crossed with a green wrinkled pea. The offspring (F<sub>1</sub>) all look yellow and round because these characters are dominant. However, F<sub>1</sub> contains 2 recessive genes which cannot be discovered by inspecting the peas. When brother and sister are mated to form the F<sub>2</sub> generation, 4 differently appearing kinds of peas are produced in the characteristic dihybrid Mendelian ratio of 9 yellow round, 3 yellow wrinkled, 3 green round, 1 green wrinkled. The appearance of a 9:3:3:1 ratio in F<sub>2</sub> proves the characters to be hereditary and proves 2 chromosomes are involved. The 1 green wrinkled pea is of profound interest to psychiatrists. At this point, let us be content to note that only 1 "child" in 16 resembled the green wrinkled parent.

There are numerous exceptions to the classical 9:3:3:1 dihybrid Mendelian ratio. The checkerboard in Fig. 5 shows how the mating of two white flowers produced all purple flowers in F<sub>1</sub> and a ratio of 9 purple to 7 white in F<sub>2</sub>. This occurs because the dominant C chromosome produces white unless it coexists with the dominant P chromosome. The effect of these interacting dominants is the addition of the last 3 factors of the classical 9:3:3:1 to produce a 9:7 ratio. Another exception is the mating of

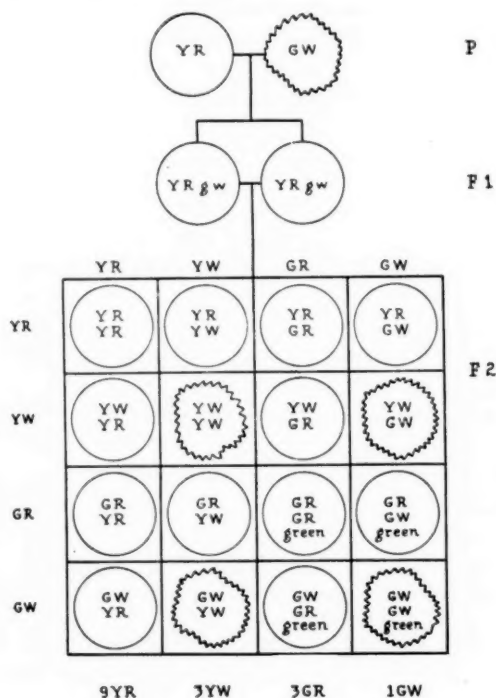


FIG. 4.—Dihybrid P differs in 2 characters. Dihybrid ratio 9:3:3:1.

two round summer squashes of different ancestry. The checkerboard in Fig. 6 gives us the amazing information that two round parents produced all disc shaped children in F<sub>1</sub> and 1/16 of the F<sub>2</sub> children were elongate! These elongate children do not resemble any of their ancestors, yet their character is determined by heredity. This fact is worth considering when we look for a family history of insanity in our patients. Were schizophrenia inherited by some such mechanism, it might appear in a patient and in none of his ancestors. Since it appears in one of 16 of the children, and the average family has 2 or 3 children, the patient might

be the only one of an enormous family to inherit the psychosis.

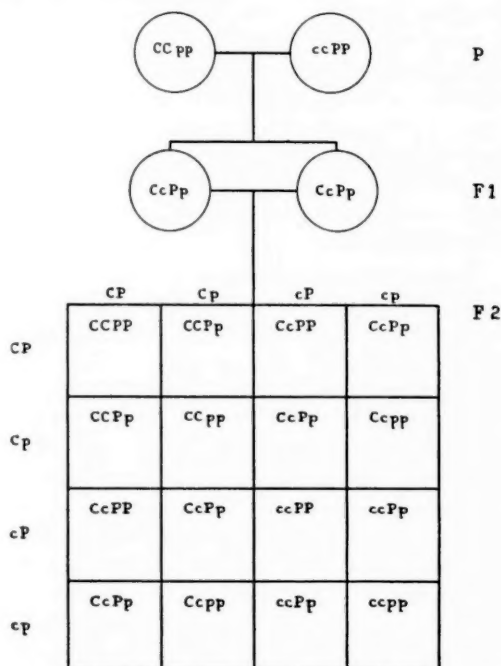


FIG. 5.—The diagram shows how interacting dominants modify the classical 9:3:3:1 Mendelian ratio to 9:7.

Both parents are white because each contains only 1 type of dominant.

All F<sub>1</sub> are purple because each contains both interacting dominants.

In F<sub>2</sub> nine contain CP and are purple, seven do not and are white.

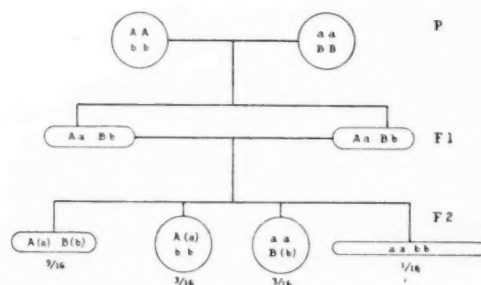


FIG. 6.—(a)=A or a

The interaction of gene A with gene B produces a disc squash.

Gene A or gene B produces round squash.

The absence of either dominant produces elongate fruit.

Since there are two round groups in F<sub>2</sub>, the ratio is modified to 9:6:1.

Another exception to the classical Mendelian 9:3:3:1 dihybrid ratio is the mechanism for the grey coat color of rodents. The C

gene is necessary for the development of any color, its absence produces an albino. A is the gene for grey. Gene C produces grey if it coexists with dominant A, but produces black if it is not. Thus the effect of gene C depends upon the presence or absence of other genes. Similar interaction of genes complicates hereditary mechanisms beyond description. Dozens of exceptions and variations of the dihybrid 9:3:3:1 ratio have been discovered.

The next most complicated genetic problem is the inheritance of a character dependent on 3 genes. The Mendelian checkerboard shows 7 kinds of F<sub>2</sub> progeny. The first kind has 27 children, 3 kinds have 9 children each, 3 kinds have 3 each, and 1 individual is unique. One could cull hundreds of exceptions from the genetic literature in which the classic 27:9:9:9:3:3:3:1 ratio is modified by gene interaction. The description of these exceptions would take volumes. They would constitute a tiny fragment of a simple problem in genetics. Man has 24 pairs of chromosomes and each chromosome probably has at least 10 genes. One can but admire Walters'(4) understatement when he says, "With 24 pairs of chromosomes in man there are, assuming independent assortment 281, 474, 976, 710, 656 different possible combinations, while the many different ways in which the genes within the chromosomes may change their alignment and cross over, increases this number beyond imagination."

Morgan has discovered that the eye color of the fruit fly is determined by 7 genes. Let us suppose that the functional psychoses are inherited by as simple a mechanism as the eye color of the fruit fly. The Mendelian checkerboard for a 7-gene process would contain over 11,000 squares. The F<sub>2</sub> ratio would not be the simple 3 to 1 ratio of the 1 gene mechanism. It would be 1 class of 2189 individuals to 7 classes of 729 each, 35 classes of 9 individuals each, 37 classes of 27 individuals each, 21 classes of 9 individuals each, 7 classes of 3 individuals each and 1 unique individual. Reference to Fig. 2 will show that the theoretically computed 3 to 1 ratio was not actually achieved with 4 progeny. In fact, a series of almost 600 children was necessary to approximate that

simple ratio. About 100,000 children would have to be bred experimentally to test the complex 7-gene ratio described above. They would all have to result from brother-sister marriages and their parents would have to be pure stocked by centuries of mother son, father daughter, uncle niece marriages.

It is evident from the foregoing checkerboards that Mendel's method is a highly specialized experimental technique which bears no relation to our patients whatsoever. As Conklin(5) points out in his "Heredity and Environment" Mendel's method cannot be applied to human beings, first, because it requires pure stock with which to begin the experiment and no pure human stock exists (Hitler's "Nordics" to the contrary notwithstanding). The average Englishman, for example, has Norse, Saxon, Angle, Teuton, Norman, Welsh, Irish, Scottish, Roman and Druid blood. Second, Mendel's method cannot be applied to human beings because it is strictly and solely an experimental method based exclusively on experimental matings. Third, Mendel's method cannot be applied to human beings because the number of offspring is too small to construct a statistical matrix to discover the ratio (and from that the mechanism which proves the character to be hereditary). Fourth, Mendel's method cannot be applied to human beings because it predicates an absolutely uniform and controlled environment while the heredity is being varied. The dynamic schools of psychiatry have amply demonstrated that no two human beings can possibly have precisely the same likes, dislikes, attitudes, fears, loves and that these characteristics are derived from various experiences (*i.e.*, different environments). No method has yet been devised which can keep a large number of human beings' psychological environments identical throughout every second of their lifetimes.

Let us now consider the third method devised for the study of heredity. This is the combination method. In this method family histories are studied and the frequency of occurrence of certain traits is noted. An attempt is then made to fit the ratio of occurrence and non-occurrence into a classical Mendelian ratio. This is supposed to prove the trait to be hereditary and dependent on

whatever number of chromosomes the ratio happens to represent. However, we have seen that Mendel's ratios appear only when pure stocks are mated under precisely controlled environments in sufficient numbers to get a proper series. Even so, the ratio only appears in one generation (the F<sub>2</sub>) and then only when the generation has been produced

had unresolved Oedipus situations due to an oversolicitous mother?

One of the best twin studies is that of Rosanoff et al.(6). They studied 142 pairs of twins of whom one or both had schizophrenia. The following table compares their results with Humm's(7) study of schizophrenia in ordinary siblings:

	Identical twins	Same sex twins not identical	Opposite sex twins not identical	Humm ordinary siblings
Both schizophrenic .....	68 per cent	20 per cent	10 per cent	3.1 per cent
Number studied .....	41 pairs	53 pairs	48 pairs	

FIG. 7.—Rosanoff et al. and Humm.

by a brother-sister mating. Our family histories are derived from impure stocks, mated at random, in uncontrolled environments, usually in numbers too small to be statistically significant, never by brother and sister matings. One example of the combination method will suffice. Goddard states that in feeble-mindedness the actual data obtained and the expected figures calculated on the assumption that feeble-mindedness is a Mendelian recessive (3:1) are in such close agreement that the assumption may be taken as verified. Suffice to say that Wilmarth reported gross cerebral lesions due to brain injury in the vast majority of 70 autopsies on feeble-minded patients. We shall never know how many of these brain injuries were due to improper forceps application, how many to rachitic pelvis, how many to an oversized child, how many to difficult labor in primiparae, how many to postnatal trauma. We do know that the feeble-mindedness was due to the environment and that it is useless to look for Mendelian ratios in the family histories of our insane patients. In other words, the combination method has all the fallacies of Galton's family history method—it cannot by observation alone tell hereditary from environmental causes.

The fourth method for studying heredity is the study of identical twins. Conveniently, these amazing individuals have precisely identical heredities. If both of a pair of twins developed the same psychosis, we would be prone to blame it on their identical heredity. But what if both suffered the trauma of desertion by the mother? What if both suffered the trauma of bullying by the father or an elder brother? What if both

Of the 41 pairs of identical twins, schizophrenia occurred in both of 68 per cent of the pairs. In 32 per cent of the twin pairs, only one twin developed schizophrenia. Yet each pair of twins had identical chromosomes. Obviously heredity cannot produce schizophrenia in one twin and not in the other. One could argue that the other twin might get schizophrenia if we waited long enough. Histories of such twins do not bear this out. Those who have known identical twins notice that they are inseparable companions. They like to wear identical clothes, go to the same schools, attend the same classes, have the same amusements. The psychological motive for always appearing together is evident. Each twin alone is just an ordinary child. When the twins are together they are pointed out as remarkable, and easily gain the center of attention. Alfred Adler and many others have shown that this striving for the limelight is a major force in human behavior. Identical twins, then, are constantly together; that is, their environments are much more alike than those of ordinary siblings. Small wonder that when the environment is poor, both succumb to schizophrenia in 68 per cent.

In the second group (same sex twins not identical), schizophrenia occurs in both twins in only 20 per cent. The heredity of these twins is the same as that of ordinary siblings. Yet Humm has shown that two ordinary siblings get schizophrenia in only 3 per cent. Since the hereditary variation is the same in both sibling groups, it follows that the difference between 20 per cent and 3 per cent must be the measure of environmental difference!

In the third group (opposite sex twins not identical) schizophrenia occurs in both twins in only 10 per cent. Again, the heredity of these twins is the same as that of ordinary siblings. The difference between the same sex twins (20 per cent), opposite sex twins (10 per cent) and ordinary siblings (3 per cent) is the measure of environmental difference, since the hereditary relationships are the same in all three groups.

#### SUMMARY

To date four methods have been devised for the study of heredity. The first is Galton's family history method. Several generations of clinical experience have shown that this method is fallacious because mere observation alone cannot differentiate hereditary from environmental causes. On the basis of their fallacious statistical studies, the Galtonians have come to incorrect conclusions such as the inheritability of rickets, tuberculosis and pellagra. It is evident that the mere recurrence of a certain trait in the same family does not prove that trait to be hereditary. This follows automatically from the fact that members of the same family have similar environments. Unfortunately, this obsolete family history method is often used today. The second method was introduced by Mendel. This a purely experimental technique which necessitates pure stock for the parent generation, a completely controlled environment, inbreeding of brother and sister and a sufficiently large number of  $F_2$  progeny to bring out the characteristic Mendelian ratio. Only by the experimental demonstration of the  $F_2$  ratio can this method prove a character to be hereditary. For functional psychoses none of the conditions necessary for a Mendelian experiment can be achieved in human beings. The method, therefore, can give us no information as to whether or not these psychoses are inherited. The third method widely used for the study of heredity in mental diseases is the combination method. This method seeks to find the characteristic  $F_2$  Mendelian ratios in family histories. We have seen that these ratios appear only in certain stages of a very highly specialized experimental technique. Occasionally a characteristic ratio can be found in simple 1-gene diseases like Hunt-

ington's chorea and polydactyly. It is a grave error to reason from this analogy that the discovery of a characteristic ratio in a few families necessarily proves the character to be hereditary. A casual inspection of family histories of mental patients shows that no such simple mechanism could possibly be involved. Goddard's classical error of trying to prove feeble-mindedness to be hereditary by this method is a typical example of the uselessness of the method for psychiatric disorders. The fourth method is the study of the mental status of twins. Although the heredity is the same in identical twins, the mere discovery of two twins with the same mental disorder does not prove the mental disorder to be hereditary. Since twins are more likely to have similar environments than are ordinary individuals, similarities in environment seem to be the cause of such simultaneous appearance of functional psychoses. If heredity were the cause of the psychosis, it would be impossible for only one twin to be affected. In Rosanoff's study of 41 pairs of identical twins, only one twin was affected in 32 per cent of the pairs. This is substantial evidence against a hereditary etiology of schizophrenia. The other three groups of cases summarized in Fig. 7 are ordinary siblings. They have identical hereditary relationships. The declining double schizophrenia rate in these three groups (20 per cent, 10 per cent, 3 per cent) must be due to environmental difference.

#### CONCLUSION

There are four methods for studying heredity as a possible etiology in the functional psychoses. The first three are either fallacious or irrelevant. The fourth, the twin method, strongly indicates that heredity plays no part in these psychoses. In fact, our poor therapeutic results in the functional psychoses seem to be due to our neglect of the environmental (dynamic) schools of psychiatry.

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## CONSIDERATION OF THE RELATIONSHIP OF PRIMARY AND SECONDARY MENTAL DEFICIENCIES, CONVULSIVE DISORDERS, AVITAMINOSIS, AND ALTERATION OF ELECTRO-NEURONAL POTENTIAL<sup>1</sup>

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Mental deficiencies will be considered as of three groups: (1) Primary mental deficiencies due to inherent germinal defect which precludes complete cerebral development. (2) Secondary mental deficiencies also due to a defect in the germ plasm which, however, is of such a nature as to result in a heredofamilial, progressive degenerative disease (1). These conditions, potentially present prenatally, may not become manifest or active for varying periods after birth (20, 26, 27, 29, 30). (3) The third group of mental deficiencies is based upon various etiological factors such as trauma, infection, toxemias and various deficiency diseases which cause mental retardation, but are not necessarily of hereditary origin.

We believe it is demonstrable that the offspring of an individual or animal deprived of vitamins will show the various symptoms of avitaminosis, inasmuch as the foetus was unable to receive a normal supply of vitamins from the vitamin-deficient mother. Vitamin deficiency results in various encephalopathies and cerebral nerve involvements (4, 10, 37, 55). Many of these encephalopathies appear almost identical with clinical entities of supposedly different etiology (2, 3, 4, 10, 58). Schilder's disease and the so called "sway-back" in lambs show very similar neuropathology (26). The myelin sheath destruction both in these conditions and in avitaminosis closely approximates that observed in the hereditary ataxias, severe anemias and diabetes (10, 13, 20, 47, 48, 50, 51, 55, 58, 79). Close relation exists between antenatal sway-back in lambs and the various pathological conditions referred to above (1, 26).

<sup>1</sup> Read at the ninety-ninth annual meeting of The American Psychiatric Association, Section on the Psychopathology of Childhood, Detroit, Michigan, May 10-13, 1943.

From the Caro State Hospital for Epileptics, R. L. Dixon, Medical Superintendent.

The relationship of these same conditions to vitamin deficiency is evident upon consideration of the pathology found in the various vitamin deficiency diseases such as beriberi and pellagra (4).

In an excellent résumé of vitamins and avitaminosis, Lewey indicates that thiamine is not synthesized in the body and large amounts are not stored (6). Therefore, a diet deficient in such items as whole grain foods, milk, eggs, etc., can result in vitamin deficiency in a relatively short time (2, 13, 59). The liver is the chief place of storage for thiamine as well as glycogen. It loses four-fifths of its thiamine stock in the first week of B avitaminosis. As soon as this occurs the peripheral nerves show increased irritability to electric stimulation and pyruvic acid accumulates in the urine and blood (2, 3, 60). (At this stage glycogen shock can be re-established by the administration of carbohydrates and insulin (4, 74).) If glycogen is not restored, fixed deposits in the nervous system will be disturbed and neuropathy and myelopathy will develop (4, 7, 47). These changes do not occur unless the liver is damaged. By means of these changes we have a definite correlation between avitaminosis and the various central nervous system lesions which are associated with liver pathology (4, 68).

Nielson states that when the deficiency of glycogen in the central nervous system becomes sufficiently low to result in coma, the damage done to the centers essential to consciousness may be so extensive that the administration of glucose does not restore consciousness, but the patient will arouse if, in addition to glucose, thiamane chloride is also administered. The use of thiamin is ineffective if glucose is not previously given (4).

The profound effect of thiamine deficiency upon the metabolic processes of the nervous

system are thus demonstrated, and a direct connection with production of unusual or abnormal EEG rhythms and vitamin deficiency is established(1, 2, 3, 7, 8, 9, 60).

Beriberi with its symptoms of peripheral sensory neuritis, cardiac weakness, lack of response to adrenalin, general malaise, lassitude and anorexia results from thiamine deficiency. Wernicke's polioencephalitis superior hemorrhagica is found to occur as the result of thiamine deficiency in chronic alcoholism(2, 3, 4, 31, 37). Thiamine is effective in senile neuralgia and trigeminal neuralgia.

The tract degeneration of the central nervous system seems to be due to deficiency in nicotinic acid and riboflavin ( $B_2$  or G)(2, 3, 4, 37). Pellagra results from lack of these vitamins ( $B_2$  or G). Coproporphin appears in the urine. There is the triple involvement of gastro-intestinal tract, skin and central nervous system. Symptoms result first from the involvement of cortex, then the midbrain, and finally the medulla: psychotic states with delusions and hallucinations of light, musical state, or a progressive dementia may all occur. The cord shows a lesion typical of subacute combined degeneration much like that produced by anemia. Multiple neuritis is also frequently present(1, 4, 14).

Vitamin  $B_6$  is said to be related to progressive muscular atrophy, as shown in experiments on rats by Antopol and Schotland(14). In rats maintained on diets deficient in vitamin  $B_6$ , muscular atrophy accompanied by tremors and convulsions occurred, even though the rats were given ample quantities of vitamin  $B_1$ (13). They also report 6 patients who showed marked improvement upon administration of vitamin  $B_6$ . Vitamin E is reported by Wechsler to have had beneficial effect in cases of amyotrophic lateral sclerosis(10).

Vitamin deficiency also results in convulsive seizures and abnormal EEG rhythms, as well as demyelinating processes in the cord and brain, according to experiments performed on pigeons and reported by Swank, Jasper, and Prados(2, 3). The evidence points undeniably to the close relationship of avitaminosis to abnormal EEG rhythms, organic brain pathology of the type so frequently seen in hereditary, progressive,

degenerative conditions in man, and convulsive seizures(1, 2, 3, 7, 10, 13, 14, 33, 36).

Epilepsy and mental deficiency are apparently closely related(16, 49). Tredgold states that there is a three-way relationship: namely, (1) mental deficiency, wherein epilepsy occurs as a complication, (2) mental deficiency and epilepsy both the result of the same cause as, for instance, traumatic organic cerebral lesions(63, 73), and (3) epilepsy with mental deficiency as the result of the effects of epilepsy on cerebral function. Tredgold also indicates that the occurrence of epilepsy with mental deficiency increases as the deficiency becomes more profound. In morons epilepsy is found in 11 per cent of cases, while in imbeciles and idiots, epilepsy occurs in 42 per cent and 56 per cent of cases respectively(16).

In an analysis of the clinical diagnoses in three groups of patients complaining of convulsive seizures, each group being examined by a different physician, with autopsy findings in 16 cases, it was noted that clinical epilepsy has a variety of causes. The prominence of certain causes seems to vary with the ideological approach of the examining physician(9, 17, 19, 56). The autopsy findings tend to minimize the so called idiopathic epilepsy and to emphasize the importance of incomplete or defective cerebral development(18, 49, 64, 80). The hereditary background of epilepsy has long been generally accepted(16, 19, 20, 44, 65), but the importance assigned to it remained as variable as the symptomatic factors until the primary importance of hereditary predisposition was demonstrated by Lennox and Gibbs in their experiments with the EEG(17, 40, 41, 44).

The following consists chiefly of excerpts from the admirable work of Ford in his discussion of prenatal anomalies and hereditary, progressive, degenerative diseases(20).

Defects of development are apparently much more common than intra-uterine diseases. This group is characterized by the following facts: (1) The condition is present at birth. (2) In contrast to familial degenerations, the condition does not run a definitely progressive course. (3) A history of similar defects is sometimes found in relatives or ascendants. (4) The "diagnosis" is

strengthened if there is a history of absence of illness during early infancy which might suggest the onset of postnatal disease of the central nervous system. In many cases of defective development of the (a) cerebral cortex, (b) basal ganglia, and other (c) suprasegmental structures the symptoms do not become evident until several months after birth, for these structures are not fully functional in the new-born, and the absence of their influence is, therefore, not at first apparent(61, 67). Thus a symptom-free period following birth does not exclude a diagnosis of defective development of the suprasegmental structures of the central nervous system. (5) Defective nervous tissue may react excessively to (a) birth trauma, (b) infection, and (c) toxemia and thus give rise to an unjustified suspicion of birth injury or central nervous system pathology due to postnatal disease.

Causes of defective development of the central nervous system(20, 32, 44): (1) Abnormal germ plasm, (2) Effect of unusual mechanical action, chemical action, and temperature action on the fertilized ovum (20, 32).

In explanation of the three types of action and their effect on the fertilized ovum, it has been proven that (a) by needling certain areas of a fertilized egg, (b) by placing it in different types of solution, (c) or by keeping it in an ice box for a brief period, it is possible to show that local defects of development may be caused by temporary inhibition of embryonic oxygenation(20, 32, 76). Stockard states that each organ develops in a definite sequence and has a certain period of maximum growth. If, during the period when a certain organ is developing most rapidly, the metabolism of the embryo is inhibited either by cold or by placing it in an unfavorable medium, the organ will never attain its proper growth. By careful timing, he has been able to produce defects in almost any organ at will(85). It is possible, therefore, that defects of development can result from even transient disturbances of embryonic metabolism, as may be caused by defective implantation or infarction of the placenta(77). Maternal toxemias and the effects of certain dietary deficiencies must also be considered(20).

The above is especially pertinent in those cases in which certain cerebral structures cease to develop at a specific period of fetal life and where no evidence of hereditary influence can be shown(9, 20, 32).

However, congenital defects are usually dependent on recessive, rather than on dominant factors; as a result of which the hereditary nature of a particular congenital defect is not always evident unless a complete study of the family tree is made(32).

Injury or disease occurring during the course of development may not only destroy the affected structure, but may inhibit the development of closely related structures.

Etiological factors are obscure where actual destruction of the central nervous system tissue occurs in utero(1, 32, 70). (1) Infectious processes may be an etiological factor. However, in congenital syphilis alone has this been established. (2) X-ray of the pelvis during pregnancy causes a defective nervous system at the time of birth. (3) X-ray of the sex glands results in sterility and it is claimed that if the glands are X-rayed prior to conception, in a dose not sufficient to cause sterility, the resulting fetus will be defective. Maternal toxemias or disturbances of metabolism may play some part in these conditions(16, 20, 32). (4) Degenerative diseases of the nervous system in which the white matter is chiefly involved are commonly determined etiologically by hereditary factors. There are, however, some (*i.e.*, Schilder's disease, neuromyelitis optica, and disseminated sclerosis) in which this hereditary factor is questioned. These conditions are very similar, indeed, from a pathological point of view and, in addition, there is no evidence that the etiological factor is other than familial(1, 4, 10). There is no resemblance to any of the infectious conditions of established etiology, but there have been cases reported by Symonds, and Collier and Greenfield, which undoubtedly were familial(21, 22). Hence it seems reasonable, until more accurate knowledge is obtained, to include these cases with the familial leukopathies of diffuse progressive degeneration. Another group of diffuse degeneration involves chiefly the gray matter. Some have been shown to be primarily familial etiologically. Others seem to be

based on acquired infection and toxemias (exogenous and endogenous), and still others appear to exist (Hall) (23) coincident with disorders of the internal secreting glands and hepatic disease (cirrhosis) (hepatolenticular degeneration) (4, 7, 20). Wilson's progressive lenticular degeneration has been shown to be identified with hepatolenticular degeneration. Cases of double progressive athetosis, typical Parkinsonian syndrome, and tortion spasm or dystonia syndrome have all been shown by Barnes and Hurst, and Greenfield, Poynton and Walshe to be but various manifestations of the progressive hepatolenticular disease (24, 25).

There are several other processes of degeneration which involve the basal nuclei more or less selectively. Most studied is Huntington's chorea which is associated with lesions in the lenticular nucleus and cerebral cortex. Another well-known condition, dystonia musculorum deformans, is said to be confined to the Jewish race, and there is no hepatic cirrhosis with which pigmentation and degeneration of the globus and substantia might occur (as a rule several in the same family).

The hereditary ataxias are confusing. Friedrich, Marie, *et al.*, described several conditions known by their names, which in reality are probably variations of one condition. The various familial spastic paraplegias and spinal muscular atrophies are linked together in the same way.

Among the degenerations of the peripheral nerves, hypertrophic interstitial neuritis has a distinctive pathological picture and is probably a disease entity. Peroneal muscular atrophy may occur with other conditions such as hereditary spastic paraplegia, so it may have some relation with the large group of spinal degenerations referred to above (4, 20).

The descendants of patients suffering from juvenile cerebromacular degeneration show pigmentary degeneration of the retina. This would tend to classify retinal degeneration in the group of macular degenerations, but Leber's optic atrophy is associated with spastic ataxia and club foot. Thus classification becomes involved (20, 32).

Certain myoclonic types of epilepsy show an amyloid-like deposit in the ganglion cell.

This is considered a specific pathological process by Dr. Freeman (5). There are other myoclonic epilepsies that do not show this pathology (4).

In considering the inheritance of disease of the central nervous system, according to Baur, Fischer, and Lenz, an analysis of the family tree produces apparent discrepancies and irregularities (32). The Mendelian ratios are rarely approximated with even reasonable accuracy, as contrasted with results in breeding of plants. Undoubtedly the small human families and the difficulties in securing complete histories are largely responsible for these discrepancies. There is another pseudo-confusion, that is, the occurrence of several cases of a given disease in a family without a history of this disease in its ancestors. For example, amaurotic idiocy almost invariably acts in this way, and gives the impression that the disease arises anew with each case. In reality, however, this is merely what one might expect of a recessive characteristic which is dependent upon genes which have but small incidence in the population and; it is only when two such genes are brought together by chance that the characteristic becomes overt. It is much harder to explain why a certain disease appears to act as a dominant in one family and a recessive in another. There are two explanations: 1. That we are really dealing with two separate diseases. 2. That the disease is dependent on several pathological genes which may be so closely attached to one another in the chromosome that they usually act as a unit, but may, under certain conditions, become separated. Thus a given individual might possess an incomplete set of these pathological genes which would require union with the complementary genes to produce the disease in overt form (20).

Spontaneous variation or mutations have been noted in experimental animals and the variations are known to be transmitted to the offspring. No doubt the morbid factors responsible for heredofamilial disease of the central nervous system arise in the same way. Heredofamilial dysfunctions of the central nervous system are of two groups: (1) Incomplete development due to hereditary factors, which remain static, and (2) Progressive, degenerative disease, as previously

stated, due to hereditary factors, the conditions being potentially present at birth but not necessarily becoming evident for variable periods following birth(20, 32).

According to Baur, Fischer, and Lenz, mutation is the greatest source of alteration in individual characteristics. Hereditary defects undoubtedly occur as mutations and by the definition of mutation become hereditary characteristics.

Mutations have been shown to be produced by exposure of the ovum to X-ray, alterations of temperature, and various chemicals and toxic substances(20, 32, 38). Factors altering the normal metabolism of the germinal cell during the period of rapid growth following fertilization tend to produce mutation. Avitaminosis produces an altered metabolic function of all cells of the individual suffering from such deprivative disease. There is abundant evidence that reduction of normal supply of either oxygen or glucose results in neuropathological changes(2, 3, 7) and by analogy a relation exists between avitaminosis and cell metabolism(8, 34, 35, 36, 62, 72). Therefore, the relation of avitaminosis and production of mutations is a logical conclusion, inasmuch as definite evidence exists that other factors which generally alter cell metabolism(20, 80) will produce mutations.

#### HYPOTHESIS

Every person has a tendency toward convulsiveness(19). The normal person has a high threshold against convulsiveness so that usual or even minor abnormal stimuli do not result in convulsiveness. Every individual possesses a certain potential of neuron force which is available for release to act as nerve stimuli in the normal reactions of the individual to his environment(17). The generation of this normal neuron force and its normal release is observed in visual terms as a normal EEG rhythm. Some persons thought of as having a low convulsive threshold have a tendency to uncontrolled release of this potential when even normal or, at most, minor abnormal stimuli are received(9, 57); such an individual shows an abnormal EEG rhythm superimposed on the normal rhythm of normally functioning brain cells(9, 39, 40, 42, 46, 62).

The potential of neuron force varies in every individual according as the necessity for reaction may vary(17, 45). If abnormal stimuli are supplied or applied to the brain, reaction to these increased stimuli is required. Hence, the usual potential of neuron force is greatly increased. If the unusual stimuli are enough, this potential will reach a point greater than the individual's threshold of mass release and a convulsion results(9, 28, 33, 35, 42, 81).

We have said that certain persons thought of as having a low threshold show a dysrhythmia superimposed on the normal rhythm of normally functioning brain cells(34, 40, 42). We know from observation that abnormal functioning brain cells result in a dysrhythmia(12, 15, 34, 40, 42, 43, 62, 69, 75). Example—Brain cells surrounding a lesion of the cortex or a neoplasm, either of which causes change in normal function of proximal brain tissue.)

If, as has been asked, a lesion or tumor acts as a precipitating agent to mass release of the neuron force, why does it not so act continuously so that mass release would be constant or, in other words, why does not such a person suffering such a precipitating agent show constant convulsion instead of only occasional convulsions?

The answer is that perhaps the lesion does not act as a constant release stimulus, but that the dysrhythmia which occurs in the adjacent brain tissue acts as an "excitor" upon the usual neuron force and thus a markedly increased potential is gradually built up which eventually surpasses the individual's threshold of convulsiveness and a convulsion ensues(9, 19, 53).

Certain types of dysrhythmia are known by observation to indicate epilepsy or potential epilepsy(9, 12, 70, 71). It seems reasonable to suggest that these "certain types of dysrhythmia" correspond to the "added" or "excitor" current which, when applied to an electric generator, cause greatly increased potential for the generator(78). Thus, all persons showing epileptic dysrhythmia are not, perhaps, suffering from a lowered threshold of convulsiveness but rather from high potentials that accumulate too rapidly and too greatly. This does not imply that individuals do not vary in threshold levels,

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but is intended to explain why lesions which result in certain types of dysrhythmia cause occasional convulsions instead of constant convulsiveness(42).

The above hypothesis does not conflict with or displace the idea of variable threshold levels of convulsiveness and the consequent reaction to stimulation of various individuals. It does suggest, however, that certain stimuli act as "exciters" to increase the neuronc potential, as well as a precipitating agent for the release of electro-neuronic energy. So much for dysrhythmia due to organic brain disease.

The undoubted hereditary factor must be considered(17, 19, 44). Lennox has established grounds for the belief that for every clinical case of epilepsy 25 of his near relatives show a similar dysrhythmia and are probably subclinical or potential epileptics (17, 44).

Dietary deficiency or avitaminosis results in organic neuronc change(7, 59, 66); besides the involvement of neuronc cells the germ plasm cells and all cells undergo a similar and simultaneous organic change which may result in a mutation so that future generations possess an altered hereditary factor(30). Hereditary dysrhythmia may be this factor.

Any one of many factors (X-ray, oxygen, dextrose, etc.(7, 8, 9, 11, 30, 38, 47, 52)) which affect the germ cells result in similar effects (i.e., mutation).

An individual inheriting such a dysrhythmia, which has the same mechanism as a dysrhythmia produced by organic brain disease, tumor, trauma, etc., tends to remain subclinical and usually becomes overtly epileptic only when subjected to minor trauma, infection, or fear and frustration, etc., which supplements the already present predisposition to epilepsy(9, 12, 15, 19, 42). Thus, most individuals are little affected by lesions which, when found to occur in predisposed persons, result in the onset of recurrent convulsive seizures(17).

This hypothesis is only tentative and conjectural and requires repeated exhibition of corroborative evidence in physiological results by chemical, physical and electrical reactions produced by repetition of the vari-

ous experiments from which the data are drawn and upon which this concept is built.

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## ELECTROENCEPHALOGRAPHIC STUDIES IMMEDIATELY FOLLOWING HEAD INJURY<sup>1</sup>

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As yet no satisfactory pathological or physiological basis has been established for cerebral concussion. The word "concussion" or "commotio cerebri" has been used for centuries but in reviewing the literature it is obvious that there is no agreement regarding the exact meaning of the term. Trotter(5) indicated that it was "an essentially transient state due to head injury, which is of instantaneous onset, manifests widespread symptoms of a purely paralytic kind, does not as such comprise any evidence of structural cerebral injury, and is always followed by amnesia for the actual moment of the accident." Although many agree with Trotter that concussion of the brain occurs without a demonstrable cerebral lesion, others believe that a minor degree of cerebral contusion and hemorrhage is always present. Denny-Brown and Russell(1) stated that "concussion is a generalized reversible 'molecular reaction' induced by physical stress. The stress must be general and must reach a certain critical speed of application." Williams and Denny-Brown(7) have demonstrated electroencephalographic changes in experimental animals following cerebral concussion. By making electroencephalograms upon a large number of patients with mild head trauma as soon as possible after injury it was thought that some light might be thrown on the mechanism of the production of concussion and the onset and duration of abnormal electroencephalographic activity where concussion was presumably uncomplicated by contusion and laceration of the brain.

<sup>1</sup> Read at the ninety-ninth annual meeting of The American Psychiatric Association, Detroit, Michigan, May 10-13, 1943.

The work described in this paper was done under a contract, recommended by the Committee on Medical Research, between the Office of Scientific Research and Development and the University of Oregon Medical School.

### ELECTROENCEPHALOGRAPHIC STUDIES IN PATIENTS WITH CRANIOCEREBRAL INJURY

Several reports have appeared in the literature on the results of electroencephalographic studies in both recent and old head injury cases. Jasper, Kershman and Elvidge(3) stated that in cases of acute injury to the head cerebral trauma was indicated in the EEG by (a) random or regular delta waves varying in frequency from less than 1 to 6 per second; (b) poor regulation or disorganization of the alpha rhythm; and (c) epileptiform discharges. It was their belief that the EEG provides a sensitive objective measure of recovery, electroencephalographic abnormalities being gradually replaced by normal activity as the patient showed clinical improvement. They further believed that post-traumatic syndromes due to malingering or hysteria were clearly differentiated from the electroencephalographic examination since in such cases none of the characteristic abnormalities associated with genuine cerebral trauma was obtained.

Marmor and Savitsky(4) studied cases with post-concussion syndrome and believed that the EEG is a valuable aid in the study of the sequelæ of head injury. They found that the EEGs of 8 of 11 cases diagnosed as post-concussion syndrome showed abnormal waves.

Glasser and Sjaardema(2) stated that there was a very definite tendency in their series of cases for high delta voltage to coincide with severe brain damage whereas low and medium delta voltage indicated less severe brain damage. By means of the electroencephalograph alone, however, they were unable to determine the presence or absence of subjective complaints.

Williams(6) agreed that the degree of abnormality seen in the EEG correlated closely with the clinical state of the patient.

In patients with mild head injury without residual symptoms the EEG was normal within a few hours of the accident. He thinks that a normal EEG obtained shortly after a patient has sustained a head injury of whatever superficial character, indicates that no gross cerebral damage has occurred. A normal record in a patient with stupor or confusion attributed to head injury throws doubt on the diagnosis of trauma, for recent damage sufficient to cause obvious impairment of consciousness is invariably associated with an abnormal EEG. Following his electroencephalographic studies Williams felt that his results supported the view that cerebral concussion is the result of widespread disorganization of cerebral function and not of specific damage to single structures or isolated tissues.

#### METHODS AND CASES

The study we are reporting was carried out at Kaiser's Oregon Shipbuilding Corporation which employs approximately 33,000 persons. We are indebted to both the Kaiser Corporation and the Oregon State Industrial Accident Commission for the whole-hearted spirit of cooperation which they displayed during the study. One room in the first aid station at the Oregon Shipbuilding Corporation was equipped with an electroencephalographic unit. A push-pull amplifier with a three channel ink-writing oscillograph, manufactured by Grass, was installed. In order to eliminate electrical interference from the outside a wire shielded cubicle was built. The records were taken while the patient, with his eyes closed, was in a semi-reclining position on a bed within the cubicle. When the patient was more severely injured he was not removed from the field ambulance stretcher but the patient and stretcher were placed on the bed in the shielded cubicle. The placement of six electrodes on the scalp was such as to allow bipolar recording from frontal to parietal and parietal to occipital areas on both sides of the head. Inasmuch as the application of electrodes to the scalp with collodion is tedious and time-consuming a more rapid method of application was sought. During the course of the study a head-band electrode holder with six spring pressure contacts was

developed.<sup>2</sup> (Fig. 1.) With this device it was occasionally possible to obtain records within ten minutes after the patient had been struck on the head.

During the course of the study EEGs were taken upon 197 patients who had sustained head injury. All of the patients in this series suffered from a mild type of injury. Those patients who had been injured severely were taken by ambulance directly to a hospital and there was no opportunity to make EEGs upon them at the first aid station. In practically all reported electroencephalographic studies on patients with head injury the interval from injury to the time the record was taken was seldom less than several hours. Therefore we believed that, in spite of the mildness of the injuries, EEGs taken immediately after the blow had been struck would provide a worthwhile study. In the group there were 173 men and 24 women. The age range was from 16 to 87 years, the mean age being 36.3 years. The shortest interval between injury and the time the record was started was ten minutes. Seventy-three of the 197 patients have returned at later dates for follow-up electroencephalographic studies.

As a control, records were taken during the course of the study on 211 persons who were considered normal subjects. Most of these records were taken from workers who came to the first aid station for ambulatory treatment of some minor condition other than head injury. Some records were also taken from foremen, office workers, nurses or any others who happened to be near the laboratory and would submit to an electroencephalographic examination. There were 171 men and 40 women in the control series; their age range was 16 to 77 years, the mean age being 34.3 years.

A history was taken in each case when the patient was brought to the first aid station. Opinions of the patient, witnesses of the accident, ambulance men, safety inspectors and first aid physicians were recorded and evaluated in an attempt to obtain an accurate account of the accident.

In order to evaluate the factor of old

<sup>2</sup> The head-band electrode holder was devised by George Ulett and Fred C. Claussen. (*Science*, 99: 85-86, 1944).

cerebral trauma both the control subjects and the patients with head injuries were asked whether they had experienced a previous head injury severe enough to have produced definite amnesia. Fifty-four of the 197 patients in the head injury series and 70 of the 211 persons in the control series gave the history of having had such a blow on the head. In both the injury series and the control series the average of the electroencephalographic records of those who had had a previous injury showed no increase in abnormality as compared with those who had not sustained a previous injury. All subjects in both control and injury series were likewise questioned regarding nervous and mental diseases in themselves and their families.

A general examination was carried out on all patients immediately after the electroencephalographic record had been taken. The blood pressure, pulse, temperature and respiration were recorded and all patients were examined for evidence of injury. Of the 197 patients studied 187 had laceration and/or contusion about the head. Two of the patients had tender painful necks and one had a fracture of the seventh cervical vertebra from being struck on the head. Two had skull fracture. In only 5 patients was there no external evidence of head injury but in these 5 the history and statements by witnesses that the patients had been struck on the head were so definite that they were included in the series. A neurological examination was also conducted and the functioning patient's sensorium evaluated. The account of events at the time of the accident as given by the patient enabled us to make some estimate of the period of amnesia during which he was mentally out of contact with his environment. In those cases in which there was impairment of sensibility at the time of examination the term "unconsciousness" was avoided and the state of the patient's insensibility was graded as (1) coma, (2) semi-coma, (3) mild, moderate, or severe confusion. In defining these terms we followed the usage outlined by the Medical Research Council Brain Injuries Committee of Great Britain.<sup>3</sup>

<sup>3</sup> From "A Glossary of psychological terms commonly used in cases of head injury," by the Medical Research Council Brain Injuries Committee, published by H. M. Stationery Office, London, 1941.

The scene of the accident was visited by one of us (G. U.), and an attempt made to evaluate the physical factors responsible for the injury. When the patient had been struck on the head by a falling object that object or an identical one was found and weighed and the distance of the fall measured. When the patient fell his weight was estimated and the height of his fall measured. In 74 of the cases studied some approximation of the velocity of either the falling object or the person at the moment of impact in foot-seconds and the force involved in foot-pounds was determined. Other pertinent facts concerning the accident were obtained from an efficient and highly organized staff of safety engineers.

#### INTERPRETATION OF RECORDS

To insure uniformity within this study all records taken were graded by the same persons.<sup>4</sup> The records were classified as "normal," "borderline," or "abnormal." A range of dominant activity from and including 8 to 12 cycles per second was considered normal. Slow waves below 8 per second were called abnormal. Lack of definite pattern despite high amplification and bursts of high voltage activity against a normal background were considered indicative of abnormality. The greater the amount of slow or fast activity in a given record the more the normality of the record was held in question. (Fig. 2.)

#### RESULTS OF THE STUDY

*Comparison of the EEGs of the Head Injury Patients and Controls.*—When the EEGs of the 197 patients in the head injury series were compared with those of the 211 patients in the control series it was found that 62 per cent of the control patients had normal EEGs whereas 57 per cent of the EEGs from the head injury patients were normal. (Fig. 3.) Thirty per cent of the control series had "borderline" records as compared to 33 per cent of the head injury series with this type of record. Distinctly abnormal records were found in 8 per cent of the control series and in 10 per cent of

<sup>4</sup> We are indebted to Dr. Knox Finley for his aid in record interpretation.

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FIG. 1.—Head-band electrode holder.

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the head injury series. It is thus evident that when the EEGs of the entire group of head injury patients were compared with those of the entire control group very little difference could be detected.

*Correlation of Electroencephalographic Findings with Clinical Evidence of Concussion.*—We divided the patients from whom we took electroencephalographic records within 24 hours of the injury into groups depending on an estimate of the clinical severity of their symptoms. Thirty of the total of 176 patients who had EEGs made within 24 hours of injury were sent to the first aid station because of scalp lacerations or blows on the head. On questioning, none of these 30 patients told of any symptoms except pain at the site of injury. No degree of clinical concussion was thought to have existed in these patients. Ninety-seven patients had complained of symptoms, including "dazed feeling," dizziness, "saw stars," diffuse headache, or nausea coming on immediately after the injury. There was not, however, any definite period of amnesia nor impairment of consciousness at the time the record was taken. Patients in this group were considered to have suffered cerebral trauma of +1 severity. Forty patients gave a definite history of amnesia of some duration as a result of the accident but there was no impairment of consciousness at the time the record was taken. This group was regarded as having suffered cerebral trauma of +2 severity. Nine patients exhibited mild, moderate or severe confusion at the time the record was taken. They were considered to be more severely injured and were classed as +3. A category of +4 severity was reserved for patients in coma or semicoma at the time the record was taken. There were no patients in this group. (Table I.) Fig. 4 shows the percentage of normal, borderline and abnormal records in the groups of +1, +2, and +3 severity. It will be noted that the +1 group, which falls short of true concussion as defined by Trotter, has very little deviation from the normal control group. There is a slight shift toward the abnormal in the cases of +2 clinical severity and a decided shift in the +3 category. No case which exhibited any degree of impaired consciousness at the time the

record was taken had a perfectly normal EEG and 5 of the 9 were distinctly abnormal. In none of the 9 patients in the +3 group was there any history of a previous head injury with amnesia, or a family or personal history of nervous or mental disease. Although one is perhaps not justified in expressing in percentage a group of only 9 individuals it is done here for comparison with the other larger groups. Subsequent electroencephalographic records have been taken on 4 of these 9 patients. Two records show a return to normal, in 2 the records

TABLE I

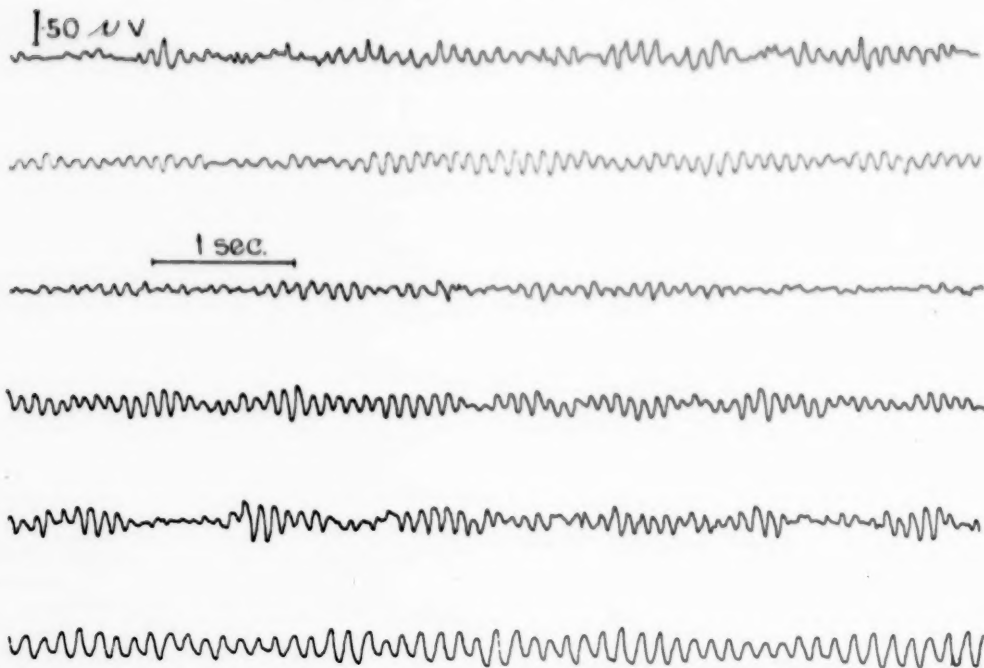
## CLINICAL CLASSIFICATION OF SEVERITY OF CEREBRAL TRAUMA

Degree	No. of patients with record within 24 hours	Symptoms
0	30	Scalp laceration and/or contusion. No cerebral symptoms.
1+	97	Dazed feeling, dizziness, "saw stars," diffuse, headache, nausea, no amnesia, for the accident,—no impairment of consciousness when EEG was taken.
2+	40	Definite amnesia of some duration. No impairment of consciousness when EEG was taken.
3+	9	Mild, moderate or severe confusion when EEG was taken.
4+	0	Coma or semicoma at time that EEG was taken.
Total	176	

have as yet not changed, and in 5 the accident having occurred very recently; no rechecks have been done. The following report illustrates a case with concussion and abnormal electroencephalographic record that subsequently returned to normal:

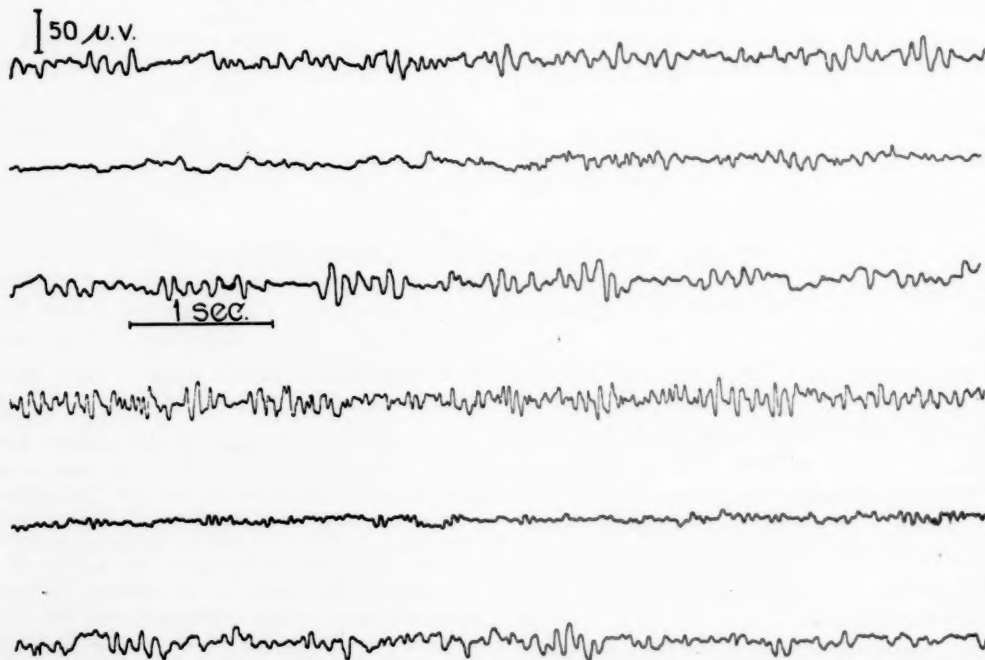
CASE 1.—This eighteen-year-old welder's helper fell about ten feet striking his head upon a steel deck. A witness said the patient was "unconscious" for about a minute. In the first aid station the patient seemed to be in a state of mild confusion. He had a 2 cm. scalp laceration in the region of the left forehead but there was no evidence of depression in the skull. Examination at the first aid station revealed no abnormality in the routine neurological examination. The patient was seen by one of us (J. R.) about 4 hours later. At this time he had no memory of the accident or the events which had

## SAMPLE NORMAL RECORDS



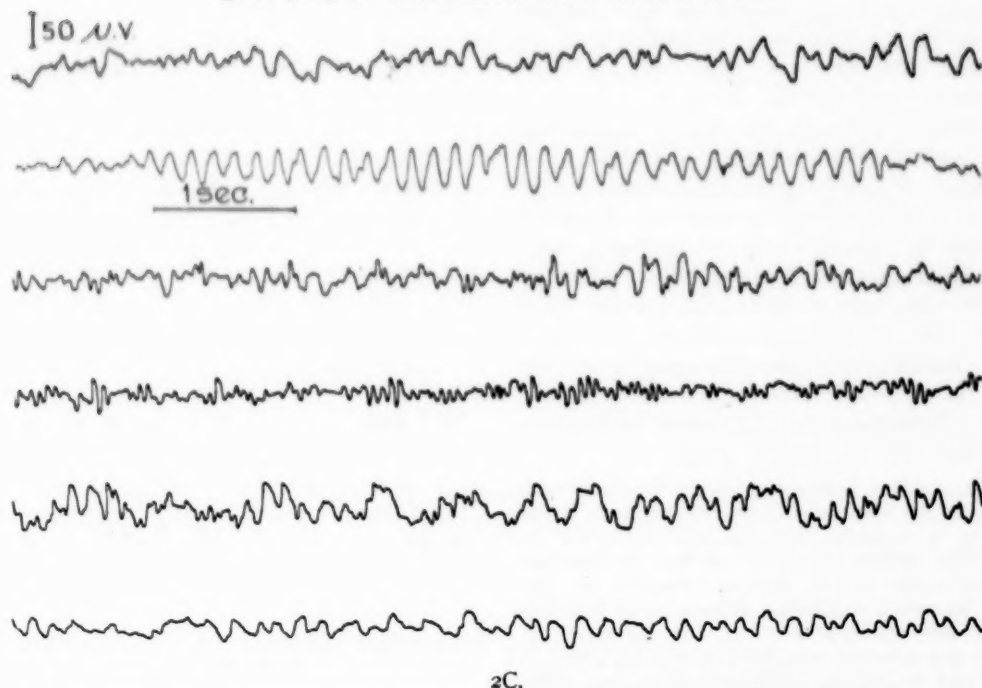
2A.

## SAMPLE BORDERLINE RECORDS



2B.

## SAMPLE ABNORMAL RECORDS



2C.

FIG. 2.—Examples of normal, borderline and abnormal electroencephalographic records. There are six cases in each group and each record is from the left parieto-occipital lead.

occurred at the first aid station. His blood pressure was 104/60 and his pulse 80. The neurological examination again revealed no abnormalities except that the right pupil was slightly larger than the left. Roentgenograms of the skull showed no fracture. The clinical diagnosis was cerebral concussion. Fig. 5 illustrates the electroencephalographic

sooner after the injury one can take the electroencephalographic record the greater the chance of obtaining an abnormal record. We were able to obtain electroencephalographic records on 53 patients within 30 minutes of the time of injury. Seventy-one

COMPARISON OF TOTAL NUMBER OF CONTROL CASES (211) WITH TOTAL NUMBER OF CASES OF HEAD INJURY (197)

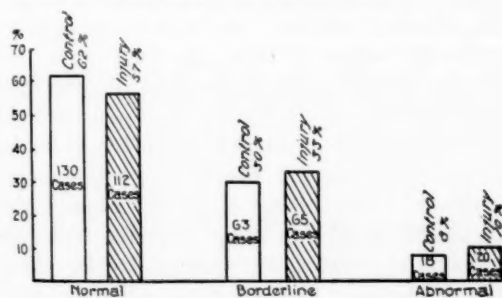


FIG. 3

findings on this patient at various intervals following head injury. A completely normal record was obtained 16 days after injury.

*Time Interval Between Injury and Taking of the Electroencephalogram.*—If the disturbance in the brain cells in concussion is a reversible process then it follows that the

RELATION BETWEEN EEG ABNORMALITY AND THE CLINICAL SEVERITY OF THE CEREBRAL TRAUMA

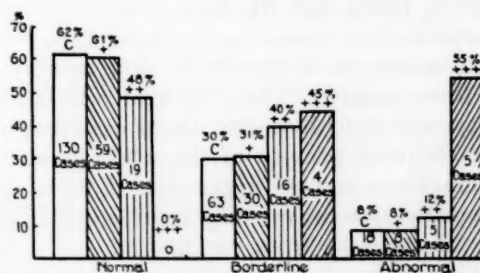


FIG. 4

patients had their EEGs taken 30 to 60 minutes after the accident. Fifty-two records were obtained when the elapsed time was between 1 and 24 hours, the vast majority of these being obtained before 2 hours had elapsed. Records on 21 patients were taken when more than 24 hours had elapsed since

injury. It was found that the percentage of distinctly abnormal records was slightly greater in the patients examined within 30 minutes than in those examined after 30 minutes. Nine of the 20 patients having abnormal records in the injury series had their records taken within 30 minutes of the accident. It would seem, therefore, that if one is to detect a large percentage of abnormalities in the EEG in the patients with mild head injuries such as those we have studied one must examine the patients very early. The following case illustrates the fact that a normal electroencephalographic record may be obtained within 15 minutes of the time a patient sustained a true concussion as judged by his clinical symptoms:

CASE 2.—This twenty-eight-year-old painter was struck in the mid-occipital region and back of the neck by a 15-pound piece of wood which fell 50 feet. The patient had on a felt hat but was not wearing a steel helmet. He was "knocked out" for a few seconds and suffered an amnesia of approximately one minute's duration. At the time the record was taken 15 minutes later he was not confused and he had no complaints. (Fig. 6.) Neurological examination showed he had slight nystagmus and hypoactive tendon reflexes.

It was obviously impossible to demonstrate the time of onset of the abnormal waves in cases of human concussion. If information is to be obtained regarding the abnormality of the electroencephalographic record immediately after injury the work must be done upon animals with the electrodes in place at the time the blow is struck. In their experimental work upon cats, Williams and Denny-Brown found that the time of onset of abnormally slow waves in all cases where concussion occurred was in the neighborhood of three minutes. They felt that concussion is associated with diminution or cessation of the electrical activity of the whole cerebral hemispheres and the appearance of these abnormally slow waves may represent a stage in the recovery from concussion.

*Correlation Between Physical Factors in the Blow and Abnormality of Electroencephalographic Record.*—Falling objects are a relatively common cause of concussion among shipyard workers. Steel helmets not only reduced the number of head injuries but also complicated the difficult task of estimating the physical factors involved in the blow. Another feature which at times hindered mathematical expression of the

forces involved in a given accident was the difficulty of determining accurately how far an object fell. The weight of the object was not difficult to determine as it could usually be found. Whether the blow was direct or glancing was often impossible to determine. When a board of some length fell it was impossible to know if the full weight struck the patient on the head. The forces involved when the patient fell were even more difficult to determine. The rapidity of movement of the head at the moment of impact might be greater or less than the acceleration of gravity because of muscular movement during the fall.

We have recognized that even under the relatively favorable conditions in which we were situated at the Oregon Shipbuilding Corporation it would hardly be possible to determine accurately the velocity at impact

TABLE II  
RELATIONSHIP BETWEEN PHYSICAL FACTORS AND EEG RECORDS

EEG record	Average velocity at moment of impact	Average force
Normal .....	23.56 ft./sec. Range 8-56	314.3 ft./lb. Range 4-740
Borderline ....	25.4 ft./sec. Range 8-50	550.6 ft./lb. Range 7-2400
Abnormal ....	35.9 ft./sec. Range 16-62	1266.6 ft./lb. Range 20-4500

and the foot-pounds of energy involved. However in our series there were 74 cases in which some estimate could be made of the physical factors. In 73 the velocity of either the object striking the patient or the velocity of the patient's head at termination of a fall was expressed in feet per second. In 67 cases it was possible to arrive at some kind of a figure for foot-pounds of energy involved in the blow. Common experience has taught us all that the greater the force of a blow the greater the damage to the skull and cerebrum. The question whether concussion is related to the force of a blow or to the acceleration or deceleration of the head has been recently investigated by Denny-Brown and Russell. In our series the average velocity at the moment of impact was 23.6 feet per second in the group with normal electroencephalograms, 25.4 in the borderline group, and 35.9 in the abnormal group. (Table II.) It is of interest that the thresh-

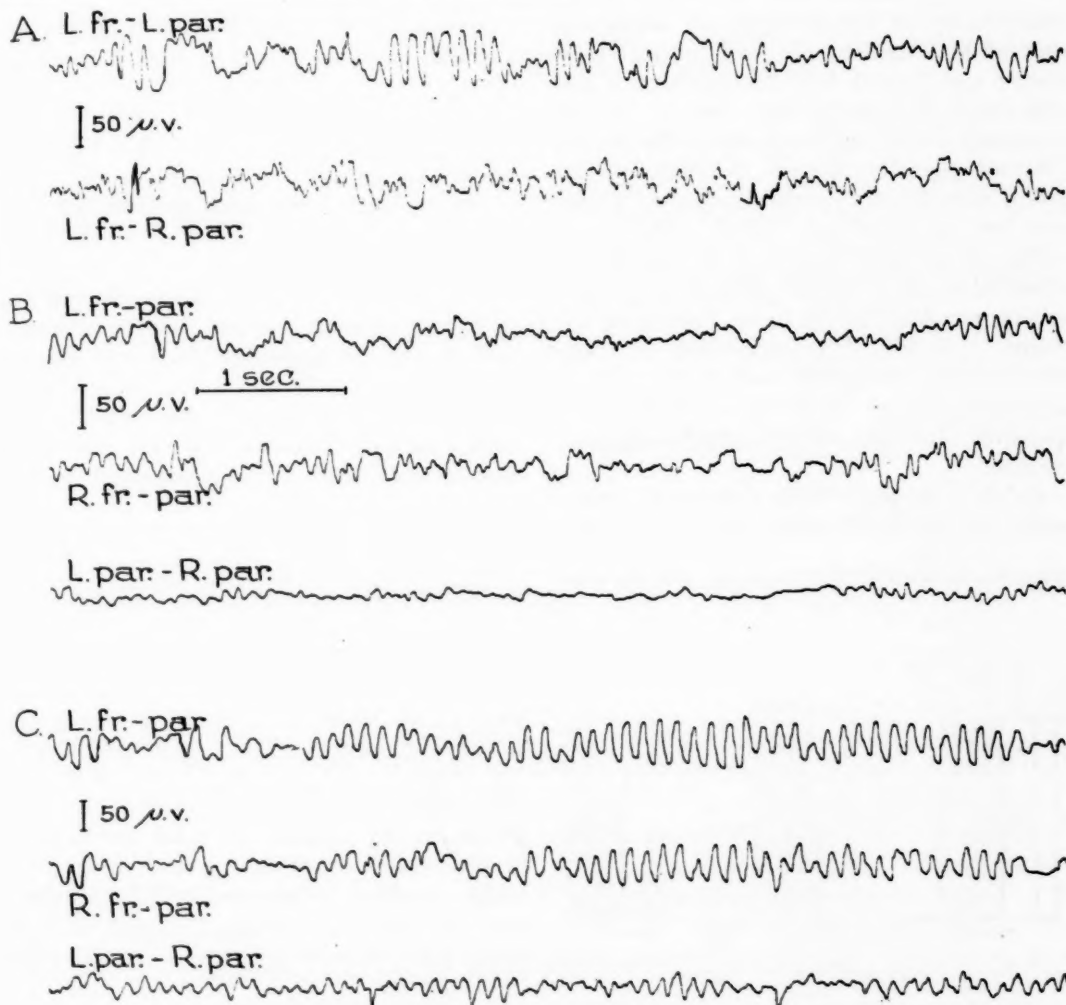


FIG. 5.—Electroencephalographic records in Case 1. (A) Thirty minutes after the trauma. The record showed activity from 4-9 per second, much of it above 50-60 microvolts. It was definitely abnormal. (B) One hour and twenty minutes post-trauma. Decreased voltage except for occasional bursts. Disappearance of some of the slow, rolling activity. Occasional 5-8 per second waves still in evidence. The record was still considered abnormal. (C) Sixteen days after the trauma. Nine per second activity. Well organized pattern but high voltage. The record was now completely normal.

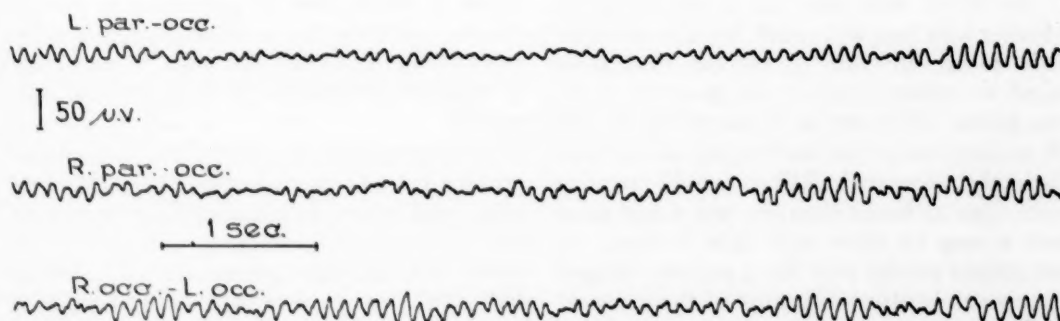


FIG. 6.—Electroencephalographic record of Case 2.

old velocity at the moment of impact in the cat and monkey, according to Denny-Brown and Russell, is 28 feet per second and this figure is between the average of the abnormal and borderline groups in our series. The average foot-pounds for the normal group was 314.3, for the borderline 550.6, and for the abnormal 1266.6. The range within each group was extreme but this is expected in view of the difficulties of estimating physical factors in an individual accident. It is difficult to judge from our data whether it is the force as such or the rapidity of acceleration or deceleration which is responsible for the electroencephalographic changes.

*Relation Between Time Loss and Abnormality in the EEG.*—Only 20 of the entire

he would have been right 6 times and wrong 3 times.

#### SUMMARY

1. If mild cerebral trauma such as we were investigating produced changes in the electroencephalographic tracing the abnormality disappeared within a period of minutes in the vast majority of cases.

2. Patients who gave a history of amnesia following cerebral trauma, but were clear mentally at the time the EEG was taken, showed only a slight increase in the percentage of abnormal records as compared to the control series. This was true even when the records were taken within a few hours of the accident.

3. If there was an impairment of consciousness of any degree at the time the EEG was taken, abnormality in the EEG was the rule.

4. Electroencephalographic records taken within 30 minutes after patients sustained head injury showed a greater percentage of abnormality than those taken after 30 minutes had elapsed. The rapid disappearance of abnormal electroencephalographic findings points, in our opinion, to some mechanism in concussion other than petechial hemorrhage, cerebral contusion, embolic phenomenon, or any other histopathological change which must of necessity require several days to disappear.

5. In the patients with abnormal electroencephalographic records the average velocity of the striking object or of the falling head at the time of impact was greater than the velocity necessary to produce concussion in experimental animals as determined by others. The average velocity of the striking object or falling head in patients who showed normal or borderline electroencephalographic records was less than the velocity necessary to produce concussion in experimental animals.

6. The study of the electroencephalographic records taken immediately following mild head injury was less reliable than clinical judgment in predicting time loss from work. An ultimate opinion of the value of EEGs in this respect will depend upon a study of a group of more severely injured patients.

COMPARISON BETWEEN EEG RECORDS AND TIME LOSS AFTER INJURY

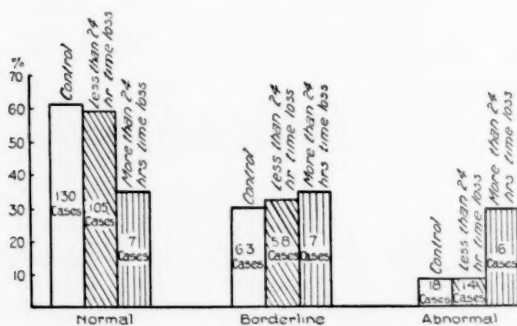


FIG. 7

197 patients claimed more than 24 hours loss from work following injury. Among the patients who took more than 24 hours time off, 6 patients (30 per cent) had abnormal electroencephalographic records whereas among those who took less than 24 hours off 8 per cent had abnormal records. (Fig. 7.) If the EEG was used as a prediction of whether time loss will result from an accident it is rather inferior to clinical evaluation based on observation at the time the EEG was taken. For example if one predicted that all 20 patients in the head injury series with distinctly abnormal EEGs would require more than 24 hours time off, one would have been wrong 14 times and right 6 times. If one should predict that the 9 patients judged most severely injured because of their mental confusion at the time the EEG was taken, would require more than 24 hours time off

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## THE CARE OF THE MENTALLY ILL IN NEW YORK<sup>1</sup>

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The investigation of which this is the report was instituted by Governor Dewey in an apparently sincere though somewhat misguided endeavor to improve the treatment of the mentally ill. An unnecessarily alarming report of the prevalence of amebic dysentery in one of the state hospitals, and some wartime laxity in administration seemed to the Governor to furnish evidence of "an administrative breakdown in the Department [of Mental Hygiene] as a whole, which warrants further study and investigation." In considering the appointment of a Commissioner of Mental Hygiene, the Governor was evidently much impressed by the magnitude of administrative responsibility in the position. A bill was hastily passed by the legislature which dispensed with the statutory qualifications for the position, in order, it was reported, to enable the Governor to appoint someone who was primarily an administrator—possibly a layman. Never before in New York had legislation so vitally affecting the care of the mentally ill been passed with so little consideration and without opportunity for public hearings. The proposal to appoint a layman aroused considerable protest, including a resolution by The American Psychiatric Association, and eventually the Governor announced: "I think I have found a man who knows both the administrative and psychiatric sides of mental care." This man was the director of the Vanderbilt Clinic of the Columbia-Presbyterian Medical Center. He was appointed Commissioner on June 3, 1943. His qualifications in psychiatry and in psychiatric hospital administration and practice were far short of those of his predecessors in the position.

In the meantime the Governor, on May

<sup>1</sup> Review of a report by a Commission appointed by the Governor of New York "to examine the mental hospital system of this state, and to suggest methods for improving both the administration and the treatment of patients."

26, had appointed a commission to investigate the department. It consisted of a lawyer as chairman, the Secretary of the State Medical Society, two general hospital superintendents (one a physician, the other the member of the State Assembly who introduced the bill to abolish the qualifications for the position of Mental Hygiene Commissioner), and a certified public accountant. In order that "it might make its investigation with the aid and assistance of a staff of experts well qualified to appraise conditions in the past and recommend practical improvements for the future," the commission "retained a staff of persons who had long experience in various fields of hospital management." A medical director of a general hospital was appointed full time director of the investigation. Seven "advisers" were also appointed consisting of a senior psychiatrist of the Institute of Living, Hartford, Connecticut, the director of nursing of a Connecticut state hospital, the supervisor of nursing education of the New York State Department of Education, a former lay superintendent of a general hospital, the field secretary of the New York City Committee on Mental Hygiene, the nutritionist of the New York State Department of Health, and a certified public accountant. Five "advisory committees" were added; on medical care, nursing care, psychiatric social service, hospital administration, and dietetics and nutrition. These committees contained professors of neurology, medicine, surgery, pediatrics, pathology, nursing, and nutrition; superintendents of general hospitals, directors of general hospital schools of nursing and of social service and nutrition departments, and one director of nursing of a hospital for the mentally ill; also officials of welfare, nursing, social work, and other organizations concerned with health and disease.

It is remarkable that of the 49 "experts" of which this impressive body of investigators consisted, only an assistant physician

and 2 nurses were apparently qualified by experience to observe and advise understandingly in regard to conditions and requirements that are peculiar to administration and practice in hospitals of the type to be examined. Three or four others may have had more or less limited experience in connection with comparatively small psychiatric departments of general hospitals. Of 9 hospital superintendents, 6 of whom were physicians, not one was superintendent of a hospital for the mentally ill. One looks in vain for the name of someone known to be "well qualified to appraise conditions in the past" in the history of the care of the mentally ill and of the development and operation of the provision made by the State of New York. In consequence, historic perspective, consideration of the social, political, and economic conditions which control the development and operation of the department, and of the differences between hospitals for the mentally ill and those for other sick persons are strikingly lacking in the report. The commission reports that not "everything is bad in the department." If anything worthy of unqualified praise was observed, however, it was not mentioned.

Much that was wrong was reported, some conditions inexcusably wrong. Little was observed, however, that is not well known and deplored by those who are well informed concerning hospitals for the mentally ill, not only in New York but, in general, throughout the nation. The experience of the investigators was predominantly in the operation of general hospitals for the physically sick and injured. They saw from that viewpoint what was obviously wrong and did not look beyond the immediate relationships for explanations and responsibility. "The reason for this breakdown," writes a reviewer of the report, "as given by the committee is rather naïve." "Lethargic administration of the department over the years . . . slowly creeping paralysis of bureaucratic inertia . . . sheer lack of organization . . . failure to insist . . . and other similar errors of omission and commission by the department were apparently considered sufficient to explain all. It was these that *"allowed the institutions to become principally custodial"* and *"allowed*

buildings to deteriorate."<sup>2</sup> Without excusing clearly revealed faults and failures in administration, a fair appraisal of responsibility and constructive recommendations required consideration of fundamental causes which will have to be reckoned with in the future as in the past and present. Society has not yet learned to provide as intelligently and liberally for the mentally ill as for other sick persons. This is vividly presented in a recently published address by a director of public welfare of long experience in another state: "The mental hospitals of this country are no credit to the intelligence, or the ingenuity, or the social and professional standards, or the humane spirit of the American people. In no state or area has a [public] mental hospital reached a development where it can even pretend to stand side by side with our general hospitals . . . we have ignored and still ignore our obligations to this class of our citizens." This characterization is fully confirmed by the nationwide surveys of these hospitals by the United States Public Health Service, the National Committee for Mental Hygiene, and the American Psychiatric Association. The conditions observed cannot be explained nor remedied as simply as would appear from this report.

Similar superficial consideration led the commission to lend its support to the inaccurate and misleading statements which have been widely published relating to the statutory qualifications of the State Commissioner of Mental Hygiene. Neither the statute nor precedent warrant the statement in the report that in making appointments "Governors in the past have had their hands tied," nor the implication, which in the newspapers became an assertion, that because of the law only a New York state hospital superintendent could be appointed. "Five years actual experience in the care and treatment of persons afflicted with mental disease in an institution" seems a reasonable qualification for a position in which the principal responsibilities relate to institutional provision and treatment. This qualification was placed in the law in order to stabilize what was already an accepted standard so that it would be observed by successive state ad-

<sup>2</sup> Italics not in original.

ministrations with varying policies and standards. Those who are aware how political and other prejudicial considerations have controlled appointments in some other states, and have rarely, and never successfully, been attempted in New York know how important this is. The recent proposal to appoint a layman in this highly technical mental health office is a sufficient illustration. There was nothing in the law to prevent the appointment of any physician who possessed the required qualifications. In fact, of the 10 medical commissioners preceding the present one, since the department was established, 3 were not superintendents in New York state hospitals. Two had not been superintendents anywhere and one was superintendent of a state hospital of an adjoining state. A fourth commissioner was, when appointed, the first General Superintendent of Bellevue and Allied Hospitals.

Probably an outstanding superintendent of one of the New York state hospitals was usually the best available candidate. The department was originally organized under the direction of a commissioner who was such a superintendent, and most important advances were made during the administration of successors who, in most instances, had been superintendents. These were the commissioners who made it possible for these investigators to report that "on the whole, the New York institutions, with all their faults, are among the best of the mental hospitals in the nation." There are no better hospital administrators than those who receive their training and experience in hospitals for the mentally ill. Other states, and other hospitals in New York than those of the state, have on occasion looked to the New York state service for candidates for commissioner and for superintendents and other important positions in general as well as mental hospitals. As this review is being written the appointment of a former clinical director of a New York state hospital as Commissioner of Mental Diseases in Ohio is reported; also the appointment of another physician from the New York state service to a similarly important position in Michigan.

In evaluating this report, consideration must be given to the viewpoint of the investigators. General medical and surgical con-

ditions have a large place in the problems presented by the mentally ill. To the commission and their principal advisers the introduction into the state hospitals of the principles and forms of organization which operate satisfactorily in the general hospitals seemed preeminently advisable. Their recommendations relating to the medical organization were directed to "differentiation in duties and responsibilities between the administrative and clinical staffs." They failed, however, to give sufficient consideration to the intimate dynamic relation of general administration to the hospital treatment of the mentally ill. They were, perhaps, not aware that their recommendation that physicians with experience in administration of hospitals for any form of illness should be eligible for the position of superintendent of a New York state hospital was contrary to the teachings of experience of 150 years, and to universal practice. The central aim of hospital treatment of the mentally ill is readjustment to normal behavior, interests and activities, within the hospital and eventually in the outside world. The patients are under legal and moral control, the large majority are ambulatory and able to engage in industrial, recreational and social activities, much like the members of any community. The treatment must be social as well as individual, and besides specially designed forms of activity, medically directed participation in the work and other activities incidental to the operation of the hospital has a large place. The greatest advance ever made in the hospital treatment of the mentally ill was essentially in administration. Pinel, the most prominent of the proponents of this advance, near the close of the 18th century wrote that he would "place first in point of consequence, the duties of a humane and enlightened superintendency and the maintenance of order, in the services," and that "the general government of the hospital resembled the superintendence of a great family, consisting of turbulent individuals." Pursuant to this conception many experiments were made with different forms of organization. Eventually it was generally agreed that the best results were obtained when a physician well qualified by training and experience in psychiatric hospital administration and prac-

tice was placed in full charge with authority over all other persons in the organization. Understanding of the patients, and their legal, social, familial and occupational relations is indispensable in the position of superintendent. This is accepted in the organization of the best mental hospitals everywhere. It has been adhered to by New York since the first state hospital was established a century ago. The only exceptions in this country are in a few backward states in which political considerations control appointments.

The same lack of understanding of the conditions that are peculiar to psychiatric administration and practice appears in some of the other recommendations relating to the organization of the medical service. The commission considered that the proportion of physicians already provided was adequate if properly organized. It recommended that the "purely physical ills . . . could be handled much better by a small resident staff of medical and surgical internes and residents supplemented by a visiting staff of outside physicians," and that the service for these ills be organized "on a basis similar to that of a general hospital . . . the physical ills . . . treated by resident physicians particularly qualified, or by specialists in active practice who would be conducting a regular service . . . the ward physicians would be able to devote their attention primarily to the psychiatric care of the patients." More service from visiting physicians would indeed, be a welcome addition to the medical resources of the hospitals. The division of responsibility and service to patients that seems to be implied in the scheme of organization proposed for the whole medical service is, however, contrary to the nature of the medical problems presented by the patients, and to the actualities of mental hospital conditions. No reference is made to the separately organized services for acute medical and surgical cases, nor to similar services for certain forms of more or less bedfast chronic cases, for which the proposed form of organization might with modifications be adopted. The position of medical interne has long been provided for in the schedule of hospital positions, and not infrequently members of the resident staff are assigned exclusively to the services for the treatment

of acute and chronic organic conditions. It has, however, always been considered that responsibility for a mentally ill patient, whatever "purely physical ills" he might be suffering from, could be safely entrusted only to a physician who also understood his mental condition and needs.

The general medical organization proposed in pursuance of the "differentiation in duties and responsibilities between administrative and clinical staffs" is divided in the report into a "Department of Professional Care" and a "Department of Clinical Service." The head of the former is shown to be an assistant superintendent, "not necessarily a psychiatrist." His responsibility is administration of "adjunct medical services" (laboratories, radiology, pharmacy, medical records, each with a division head), nursing and nursing education, nutrition and social service, each with a director. The head of the "Department of Clinical Service" is the clinical director. He has "advisory relations" with the "Department of Professional Care." His direct responsibilities are concerned with the "medical care of patients," embracing psychiatry, general medicine, surgery, dentistry, therapies, medical education and research. The resident and visiting staffs are under his direction. It is recommended that the position of clinical director be made "approximately comparable to that of the superintendent in pay, emoluments, and distinction," in order that "a physician will not find it necessary . . . to transfer to administrative work in order to reach the highest rewards in the institution." This is in the direction of the differentiation between responsibilities previously mentioned, with a superintendent who would not necessarily be a psychiatrist, and, judging from a newspaper report of the view of the chairman of this commission, might some day be a layman. Better opportunity for a career devoted to clinical and scientific work in the hospitals would, indeed, be of advantage. It is noteworthy, however, that in considering candidates for superintendents the authorities of the best mental hospitals are disposed to show a preference for those who have a reputation in clinical as well as administrative psychiatry. A third department in the hospital organization is that of "Business Administration." It is recommended

that the title of "steward" be changed to "business manager," and that the requirements both in education and experience be increased and the position filled after open competitive examination. This would be a desirable improvement.

The quota of ward personnel was considered by the commission to be "sufficient to obtain good nursing care." Inferior nursing procedures and facilities, inadequate organization and supervision, ratio of registered nurses, and quality of attendant personnel prevented the accomplishment of this. Improved facilities, standardized ward manuals of procedures, better habit training of patients, better supervision and instruction, and increase in the proportion of registered nurses from the present 13.2 percent to 24 percent are recommended. It will be wonderfully fortunate if funds are appropriated to provide for the adoption of these recommendations. Only registered nurses with adequate psychiatric training and experience would, however, be suitable.

The occupational departments of the hospital were found by the commission to be "well run . . . as units within themselves" but not "coordinated directly with the work of the clinical director. . . . A proper coordination . . . would require that the occupational department follow up the cases who work in the hospitals. . . . Patients who work in kitchens or dining-rooms can be considered as doing necessary labor or as engaged in a program of vocational readjustment." It is estimated by the present Commissioner, the report states, that 60 to 70 percent of the patients should have some form of occupational therapy, which would necessitate doubling the number of therapists. It has been considered that the intensive occupational therapy for incapacitated and unadjusted patients was somewhat different from the employment of more or less adjusted patients in the work of the hospital. More instruction and training of the ward and industrial departments personnel in the employment of patients would in fact, be more practicable and productive. Physiotherapy, physical training, and recreational therapy, equally valuable though they are, do not seem to have received the attention of the commission, as they are not mentioned.

If the recommendations of the commission relating to dietetics and nutrition are fully accepted, a great advance will be accomplished. These include better management of food supplies by purchase and from the hospital farms, repairs and better equipment for the kitchens, better training and supervision of food handlers—employees and patients—discontinuance of patients in the dairies. The employment of a much larger number of well qualified dietitians in the hospitals and a supervising nutritionist in the central office of the department is recommended.

The disadvantage resulting from civil service policies and methods is discussed. The resumption of appointment of attendants directly by the superintendents, instead of from lists furnished by the Civil Service Commission which was introduced as a result of criticisms made in an election campaign, was commended. This experiment contributed extensively to some of the conditions criticized in this report. It is recommended that the supervising professional positions of superintendent, associate and assistant superintendent, clinical director, education director of schools, director of laboratories, director of nursing, supervising dietitian, and director of social service, be hereafter filled from lists established by open competitive examination. One advantage mentioned would be to permit the appointment to advanced positions of physicians and others who had left the service and obtained additional valuable training and experience elsewhere, and who by the plan heretofore followed, could be reinstated only in the lowest grade. The loss of two highly qualified physicians has already been mentioned.

The commission urges more cooperation between the medical schools and the hospitals in developing courses and practice periods for medical students. It considers that the hospitals present "the most attractive opportunities for internship that the medical graduate could possibly find . . . for training in many branches of medicine . . . certainly in psychiatry but equally so in various specialties of medicine and surgery." The visiting staff would be teachers of the resident staff as in the general hospitals. Improvement in laboratory facilities

and work is recommended, and a travel-study fund for each institution, to enable the members of the medical staff to attend important professional meetings and to visit centers where noteworthy medical work is being done. The relation of the Psychiatric Institute in New York City to the hospitals is considered unsatisfactory because of "lack of leadership and imagination in the department." A program similar to that followed when the Institute was on Ward's Island is proposed. The commission finds that there is no excuse for the State Psychopathic Hospital at Syracuse "as at present operated." At present this institution provides teaching facilities for Syracuse University Medical College, in which its director is professor of psychiatry, and observation and early treatment facilities for the city of Syracuse and vicinity. This institution was established in 1926 pursuant to a policy contemplated by the State Hospital Commission for the establishment of active treatment hospitals in or near the large cities, and hospitals of the colony or village type in the country for protracted and incurable cases. To abandon the Syracuse Hospital would seem to be a backward step.

The schools of nursing in hospitals for the mentally ill, which were developed realistically and accomplished a remarkable transformation in the nursing attention to patients, have been forced gradually to disband since regulation of nursing and nursing education has been entrusted to Departments of Education and general nursing organizations, which have shown little understanding of the character and magnitude of the nursing problem in the hospitals for the mentally ill. In New York the law requires the superintendents of the hospitals to conduct schools and they have survived in a limited way. This commission reports, however, that on account of expense and scarcity of teachers "an attempt to bring the schools up to a good standard would be wasteful and ineffective," and it is recommended that they be abolished as now conducted. To take their place it is proposed that a single centralized school be set up under the control of a nursing division of the office of the Commissioner of Mental Hygiene. The existing schools would then become units to which the students of the central school

would be assigned for their practical ward work. Two or more regional centers for preclinical teaching are also proposed. The central school with its branch teaching centers would be under the direction of a qualified nurse educator appointed by the Commissioner, and responsible to the Director of the Department of Nursing of his staff for the selection and admission of students and their placement in the hospital divisions for nursing practice, the plan and conduct of the curriculum, and all other matters relating to the school program. "Students are not to be thought of as working for the hospital and available to fill gaps in employee ranks, but should be given the same status as that of students in other educational institutions." State scholarships for needy students should be available. A similar central school for the training of practical nurses is proposed, the minimum requirements of the State Board of Regents to be complied with, and the present attendants encouraged to apply for admission. "The cost of conducting the school and the maintenance of those enrolled in it should be borne by the state." Presumably, the course prescribed by the Department of Education would be that adopted for practical nurses for general medical and surgical patients. To what extent this rather imposing project could be developed and what would be accomplished for the primary purpose of providing trained personnel for the care of the patients in the hospitals seems problematical. A similar experiment in another state has resulted in depriving all the hospitals of their original schools, and after a trial of over 20 years the contribution of the central school may be gathered from a recent communication from a well informed source, which closes, "This lengthy description will give you some idea how the plan of the central school has not worked." It is proposed that the title "attendant" be eliminated, and the ward personnel of the future consist of: registered nurses, licensed practical nurses, senior ward aides and ward aides.

The need of repairs and renovations of buildings observed by the investigators is attributed to failure of the department "to insist upon a regular and definite program of maintenance," and a "yearly reserve for repairs and maintenance to be placed at the

disposal of the department for allocation where it is most needed" is recommended. The reconstruction of some buildings at the older institutions, and the construction of additional reception units and units for bedfast patients, are also recommended. Most of the reception units were found by the commission "to work particularly well." It was considered "a striking commentary on the lack of statistical methods . . . that this Commission has been unable to ascertain what proportion of the patients discharged . . . had never progressed beyond the reception unit." Other observers have, however, felt more concern in regard to the number of patients who, because of the inadequate capacity of the reception services, are prematurely transferred to services in which, as described by the commission, "segregation . . . is not by diagnosis but by the type of behavior . . . acutely disturbed patients are separated from the mildly disturbed." Notwithstanding a prefatory assertion that "the approach of the commission and its staff was scientific and fact finding," several broad inferences appear in the report. What were regarded by the commission as "the almost casual way in which shock therapy has been employed and the ineffectual handling of the tuberculosis problem," are assumed to "justify the conclusion that the less tangible medical and psychiatric problems are, likewise, ineffectually dealt with." It did not seem to be inferred, however, that the administration responsible for the reception services which "work particularly well," would, if means had been provided, have so organized other services that they too would have been found to "work particularly well." The skyscraper and lower types of buildings are compared, the former being considered suitable for bedfast patients only. The recommendation of "enclosed space adjoining the buildings to which patients may go for exercise . . . with the minimum of additional supervision," recalls memories of treeless, grass denuded, "airing courts" which were condemned and discarded many years ago. Such provision would be a sorry substitute for the active curative program which the study and recommendations of this commission are assumed to inaugurate.

The commission directs attention to the important bearing of size of the hospitals on the quality of medical care. "Patients in large hospitals cannot receive the same amount of individual attention as those in small hospitals. . . . The details of administration even with good assistants become more difficult to follow. Policies are made to fit the size of the plant rather than the patients' needs." Neither this, however, nor other adverse conditions occasioned by broad state policies and by social, political and economic considerations, are mentioned in the report as extenuating circumstances in determining responsibility. The small number of superintendencies in relation to the large number of physicians who become eligible might have been mentioned. In consequence, few reach the promotion until well over 50. A recent appointment by the present Commissioner was a man of 65. The proposal of the commission to provide one or more separate hospitals for the tuberculous mentally ill would, it was estimated, reduce the patient load in the present overcrowded institutions by about 5000. This plan has been advocated by the United States Public Health Service. The commission suggests that these hospitals be located near those maintained for the tuberculous by the State Department of Health. The tuberculosis problem in the state hospitals for the mentally ill has been a source of constant anxiety and much effort for many years, and the conditions described in this report are still, as the commission asserts, "nothing less than shocking." The difficulties in dealing with it are very great, and it seems likely that, whatever other provision may be made, segregation and treatment for some cases will always be required at each of the hospitals.

Four methods of reducing the total number of patients in the hospitals are mentioned: (a) restricting admissions of patients who do not need the special type of care provided; (b) transferring non-residents, aliens, and war veterans to their legal residences and appropriate hospitals; (c) discharging such patients as can reasonably be expected to become adjusted to life outside, by means of intensive therapy in the hospitals, parole, family care, and colonies;

(d) preventing serious illness by early detection, diagnosis and treatment. The commission estimated that about 4000 of the cases of senile psychosis and cerebral arterio-sclerosis at present in the hospitals were not in need of mental hospital care. It was noted that during the last 30 years the proportion of these cases in the first admissions had risen from 13.5 percent to 35.4 percent. This is due principally to the advance in the average age of people generally—as the incidence of mental illness increases with age. The view of the commission, however, that senile psychoses are merely “the natural consequences of old age” does not dispose of the problem. Long before the problem had reached its present proportions, many cases were discharged by the superintendents or by order of the Commissioner only to be soon returned. Patients who present no particular difficulties in the organized service of the hospital may be a hard problem at home or in an almshouse. The plan of sending physicians to examine aged patients for whose admission application had been made has also been tried. The problem is psychiatric and not “primarily one of care of the aged.” This is well explained in an article by a New York state hospital physician in *The Psychiatric Quarterly Supplement* of the Department for January, 1944. The proposed integrated state, county and municipal program for the care of the indigent aged, including those with “mental deterioration due to age,” would necessitate adequately organized psychiatric services. Consideration must be given to conditions of “county care” which “state care” was adopted to abolish.

The transfer of aliens, non-residents and, as far as possible, war veterans, has been very effectively attended to for many years. War conditions have, no doubt, greatly interfered. The parole of patients and family care have also been a practice for years. The studies of the Temporary Commission on State Hospital Problems are cited at length in this report to show the extent to which the hospitals would be relieved if more resort were made to these means of discharge of patients. In 1942 the number on parole was 10.4 percent against 7.5 percent 10 years previously. This was accomplished

by means of a special appropriation for the employment of physicians and social workers for the special purpose. To maintain such a standard it was considered that the present 151 social workers would have to be increased to 271. The commission considers, also that the present number of physicians on the hospital staffs is not sufficient “to examine into the parole status of each patient.” The central medical and social service clinic recommended by the Temporary Commission to facilitate social service for parole patients from the state hospitals of the metropolitan district was approved by this commission. With a view to the prevention of serious mental illness by means of early detection, diagnosis and treatment, extension of child guidance clinics is urged as part of “every well directed system of school medical inspection.” Attention is directed to the Massachusetts law which places responsibility for such clinics upon the state hospitals. The child guidance division of the New York State Department, with a staff of 4 psychiatrists, a supervisor and 8 clinic workers, which has been operated for years, is, however, not mentioned in this report. It is recommended that the further establishment of general hospital psychopathic units and clinics at almost every hospital, public and private, “should be promoted, by means of state aid, if necessary.” This would surely mark a great advance.

The overcrowding and the need of structural repairs and extensions at the state schools and the colony for epileptics were discussed and recommendations made. A further development of the colony system and provision for the care of infants is recommended. The proposed separation of the teachable mentally deficient in different institutions than those for the lower grades would be a return to a system which was long ago discarded in New York, and is contrary to the views and practice of the most experienced authorities on the subject.

A thorough study was made of the accounting records, methods and procedures of the department and the hospitals, and many suggestions offered designed to simplify, facilitate and render more effective the business management.

Changes in legal nomenclature and pro-

cedures, some of which have long been desired, and already made in some of the other states, have, since they were recommended by the commission, been incorporated in the law. The principal recommendations are a change of the word "commitment" to "certification" by the judge, the word "parole" to "convalescent status," "insane" to "mentally ill," and "insanity" to "mental illness." The period during which a patient may be detained without legal procedure for observation and temporary treatment in state hospitals and organized psychopathic hospitals and departments connected with general hospitals, was extended from 30 to 60 days. These changes contribute to humanizing the procedures and facilitating hospital treatment for the mentally ill.

It has long been the opinion of many of those interested in the Department of Mental Hygiene that the central organization was inadequately manned. The assertion that "at no time in the past have arrangements been made for such a staff" as that proposed in the report, may be barely within the truth. Similar arrangements have, however, been attempted in the past. The conditions for their realization may have been less favorable than at present. Usually a few legislative, budgetary, and gubernatorial hurdles have to be crossed. The commission, however, presents no estimate of the increase in expense if their recommendations are adopted. It might be gathered from the report that at the time of the investigation there was no central organization, though the examples of omissions cited by the commission are 4 positions: director of nursing, dietitian, director of farms, and director of personnel. On the other hand, in the new organization the present director of occupational therapy, and the whole "Division of Prevention" and its chief child guidance psychiatrist with 4 clinic psychiatrists and 8 clinic workers, are omitted. Some of the new organization consists in part of change in titles and charting. The former "Bureau of Inspection" was considered by the commission to be "somewhat detached," although reports and personal conferences relating to inspections of the 83 state and private institutions under supervision by the department must have occasioned pretty close relations

with the Commissioner and his assistant. A "Division of Inspection" is also provided in the new setup. However, positions which are added are of great importance and there is an appearance of a new order and promise of increased activity in the scheme and description of the central organization which is most encouraging.

The laudable intention of the Governor in undertaking to improve the state system of care of the mentally ill is manifest in his recent declaration: "We are in the process of trying, at long last, to change the basic concept of our mental hospitals. . . . We must and will make them into institutions not merely of care but of cure, not of despair but of hope—hope for the restoration of mental health." It is hard to find an explanation, however, of the neglect, in his plan of procedure, of the sound lessons of experience and of the guidance of adequately qualified administrators of hospital service for the mentally ill, of which many were available in New York and other parts of the country. It is, indeed, remarkable that eminent physicians and administrators, whose experience was entirely in connection with general hospitals, should have considered themselves qualified in a very special field in which their understanding and experience were so limited. It illustrates, perhaps, a situation in psychiatry in its relations with the general medical profession which may appropriately be given further consideration in the educational program of psychiatric organizations.

Serious consequences may follow the removal from the law of essential qualifications in the position of Commissioner. In a recent publication in another state a comment on the report is that "the bar is down, and only the Governor's sense of what should be in such a matter will control his appointment. He may select a Tammany politician." The proposal that the qualifications for the position of superintendent now in the law be changed so as to admit to eligibility physicians whose experience in administration was obtained in other hospitals than those for the mentally ill would also, if adopted, result in serious impairment of the service. A trend in the views and recommendations in the report towards over-centralization of direction of the operation of the hospitals

would not be likely to contribute to a spirit of responsibility, initiative and enterprise in the superintendents and their staffs.

Nevertheless, the report presents the views and recommendations of highly qualified general hospital administrators and expert accountants, and, as such, contains much of interest and value to all who are engaged in the hospital treatment of the mentally ill. It may be hoped that, as those who are

charged with the executive responsibility for proposed changes become better informed of the actual conditions and needs, better counsels will prevail, mistakes will be corrected, and advances made in accord with sound psychiatric principles and practices. If so, and if more intelligent and liberal governmental and popular support than in the past is obtained, a notable advance toward the goal set by the Governor may result.

## ON THE OCCURRENCE OF RAPID FREQUENCY POTENTIAL CHANGES IN THE HUMAN ELECTROENCEPHALOGRAM<sup>1</sup>

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This study is presented primarily in the hope that it will attract wider attention and stimulate more interest in the rapid frequency electrical cortical potentials. These rapid cycles are of particular importance because they occur in a high percentage of the atypical or abnormal patterns obtained from patients with psychiatric disorders in addition to their occurrence in neurological conditions.

Gibbs in 1939(1) described the range of frequencies of the bio-electric brain potential changes as the "cortical frequency spectrum." For clinical purposes this spectrum may be classified into three bands: (1) slow frequencies (delta activity), less than 1 up to 8 cycles per second; (2) medium or normal frequencies (alpha activity), 8 to 12 cycles per second; and (3) rapid frequencies (beta activity),<sup>2</sup> 12 to 40 or more cycles per second.

Like any classification there are certain drawbacks and many exceptions. The author is aware that under certain physiological conditions slow and rapid frequencies are normal. Slow cycles are a normal component of the waking infant's and child's brain and during physiological sleep in both children and adults. Rapid cycles of less than 25 microvolts are a component of many normal tracings and rapid frequency cycles of more than 25 microvolts are a physiological variant during the early stages of sleep. Rapid 14-15 per second spindle cycles occur in the deeper stages of sleep.

<sup>1</sup> Supported by Grants from the Scottish Rite Masons Fund for the Study of Dementia Praecox and the Proctor Fund, from the Department of Nervous and Mental Diseases, Harvard University, and the Boston Psychopathic Hospital, and the Division of Neuropsychiatry, University of Oregon Medical School.

<sup>2</sup> The use of the Greek terms, delta, alpha and beta, are to be discouraged for they mean no more than slow, medium and fast activity, as pointed out by Gibbs(1). The Greek terms have neither descriptive nor physiologic meaning and descriptive terms at present are sufficient, as the physiological significance of the different frequencies is little understood.

Cortical frequencies much faster than 40 cycles per second occur, but these faster frequencies cannot be satisfactorily recorded with our present ink writing oscillograph and they are not readily distinguished from muscle artefact potentials.

This study is concerned with the *high voltage* rapid frequencies. By high voltage, I refer to rapid 15 to 40 per second cycles which have an amplitude greater than 25 microvolts (Fig. 1). Rapid cycles of lower amplitude occur in most normal records. The high voltage rapid cycles are concentrated mostly in the 20-30 per second band of the cortical frequency spectrum, although cycles on either side of this portion of the spectrum, *i.e.*, in the 18-35 per second sector, are not uncommon.

A six channel ink writing oscillograph of the Grass make was used, enabling one to record from six different parts of the cerebrum simultaneously. "Monopolar" and "bipolar" methods of recording were used.

If one does not use sufficient amplification, rapid activity may be overlooked. Fig. 2 illustrates how these rapid cycles at standard amplification (vertical deflection of the pen of 0.5 cm. equals 50 microvolts) may be overlooked, while with moderate amplification they become quite distinct. Although 50 microvolts is a high voltage for rapid cycles, it is average voltage for medium 8 to 10 per second cycles, and low voltage for slow cycles which not uncommonly reach 100 to 200 microvolts.

These high voltage rapid cycles occur predominantly from the anterior two-thirds of the cerebrum, particularly the frontal regions (Figs. 1, 2 and 3). When the rapid activity is equally distributed over the entire hemisphere the amplitude of the cycles is usually greatest and better organized over its anterior half (Fig. 1, samples B, C, D, E, and H). The rapid cycles may be distributed in a random, irregular fashion (Fig. 3, C-1410), or more uniform and constant with modulating swings in amplitude (Fig. 3, C-1643

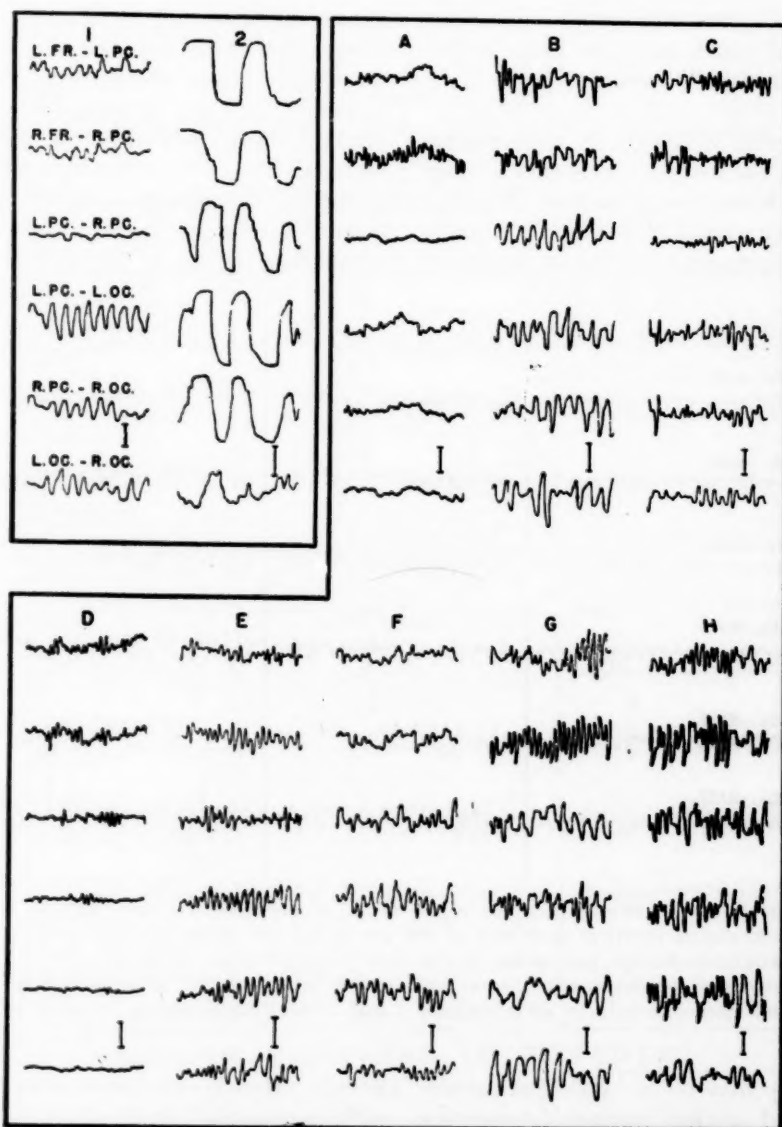


FIG. 1.—Samples A through H show some characteristic types of patterns containing rapid frequency cycles as obtained from the human brain from a six channel EEG apparatus.

Samples 1 and 2 are for comparison, Sample 1 being an average frequency tracing and Sample 2 showing an abnormal tracing with slow  $2\frac{1}{2}$  to 3 per second high voltage cycles.

The electrode placements for each of the six channels are the same: first channel, left frontal to left precentral; second channel, right frontal to right precentral; third channel, left precentral to right precentral; fourth channel, left precentral to left occipital; fifth channel, right precentral to right occipital; sixth channel, left occipital to right occipital. Each sample represents a 1-second period of recording.

In this and the following figures the vertical line of each sample represents 50 microvolts.

and C-2050), and variations in between (Fig. 1 and 3). They are often superimposed on cycles of slower frequency; for example, 20 per second cycles when superimposed on 10 per second cycles give the latter a "dicrotic" or "bicuspid" contour (Fig. 3, C-2050).

The frequency of the cycles does not remain constant but usually varies over a range of several cycles per second. The Gibbs and Grass analyzer shows that there is usually a dominant frequency (2), that is, the domi-

a period of time the number of bursts from homologous regions is about the same.<sup>3</sup>

It is important to distinguish between muscle artefact and rapid cycles, which in some instances have a resemblance. Muscle artefact is faster, being over 40 cycles per second. The muscle potentials have a biphasic positive and negative sharper spike contour with more variation in the amplitude of the individual cycles. Rapid potentials of cortical origin are more rounded and show modulating swings in the amplitude of cycle

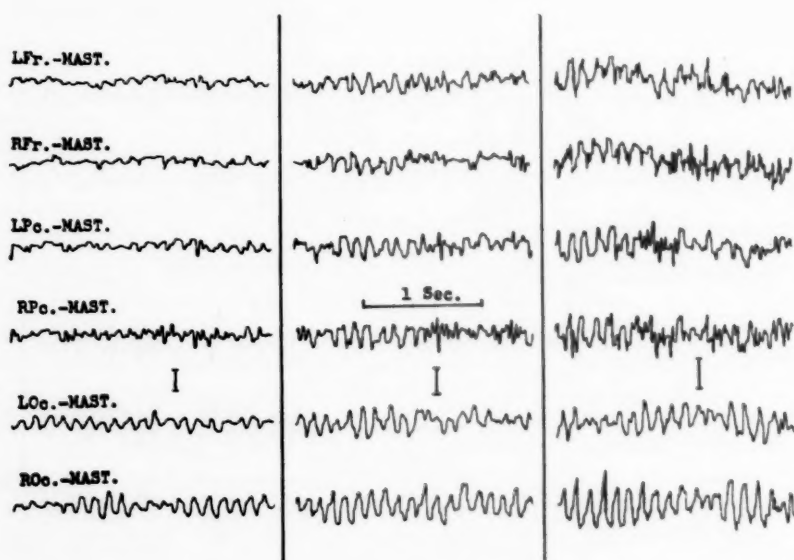


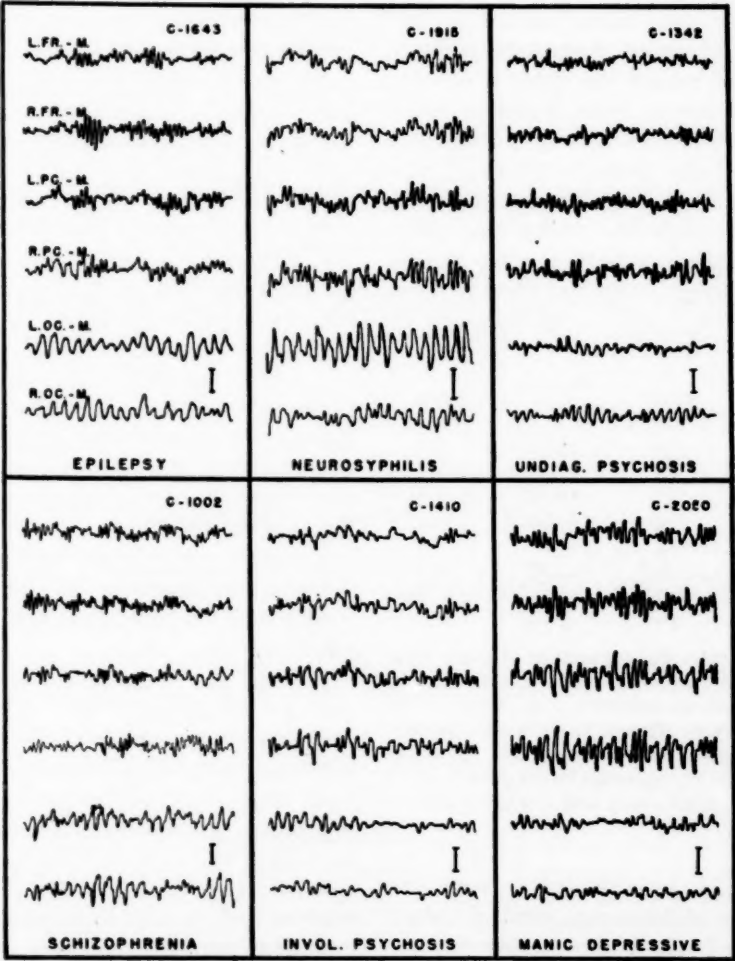
FIG. 2.—This figure illustrates how the rapid 20 to 30 per second cycles may be overlooked at the standard amplification (vertical deflection of the pen of 0.5 cm. equals 50 microvolts). In the first sample, rapid activity is barely perceptible in the first three channels, although evident in the fourth channel. The increased prominence of these rapid cycles with moderate amplification is demonstrated in the second and third channels by an additional 1 and 2 stage amplification, respectively.

nant frequency may be 22 cycles per second with scattered cycles having frequencies slightly slower or faster. The frequency often is greatest over the frontal lobes. For example, if the frequency averages 25 cycles per second over the frontal lobes, it may be 24.5 per second over the precentral, and 23.5 over the occipital regions. Usually rapid activity is symmetrical from homologous areas of the two hemispheres although there may be some difference in the amplitude (Fig. 1, samples C, D, G and H). Bursts of rapid activity do not always appear synchronously over homologous areas but over

groups. Muscle artefact is most pronounced with "monopolar" leads where the indifferent electrode (ear or mastoid) is nearest muscle. Cortical rapid potentials show up equally well and often better with "bipolar" leads where electrodes are often furthest from sources of muscle artefact, *i.e.*, from the temporal and neck muscles.

The material for this study was taken from a series of one or more EEG tracings on over 4500 neuropsychiatric disorders and

<sup>3</sup> An exception to this is sometimes seen in focal lesions where rapid activity may result, sometimes contralateral to the site of the lesion.



SIMILAR PATTERNS IN DIFFERENT CLINICAL DISORDERS

FIG. 3.—Samples of atypical EEG patterns showing a predominance of rapid 20 to 25 cycles per second. Note that the rapid activity is most prominent from electrodes placed over the frontal and central portions of the two hemispheres. These samples are all similar in this respect yet were obtained from a variety of neurological and psychiatric conditions.

No. 1 lead, left frontal to mastoid; No. 2, right frontal to mastoid; No. 3, left precentral to mastoid; No. 4, right precentral to mastoid; No. 5, left occipital to mastoid; No. 6, right occipital to mastoid. Each sample represents a 2-second period of recording.

from 300 normal individuals used as controls. The study emphasizes three points: (1) that rapid frequency patterns are widely distributed throughout all neuropsychiatric disorders; (2) that similar types of rapid frequency patterns are found in a variety of neuropsychiatric conditions; and (3) that various types of rapid frequency patterns are to be found within the same neuropsychiatric clinical entity. Table I gives a rough idea of the quantity of these rapid frequency patterns in the EEG tracings of the different clinical groups, including the control series.

These rapid frequency cycles have been noted by investigators both abroad and in this country. Berger described them and be-

been acquainted with the work of Gibbs, Gibbs and Lennox on the occurrence of these rapid frequencies in epilepsy, I might have been led to the belief that they were limited to the major psychoses. It became apparent, however, that high voltage rapid frequency cycles are seen in a wide variety of neuropsychiatric disorders (Table I and Fig. 3).

If one divides the case material into the psychiatric and neurological groups, it is apparent that rapid activity is a more common type of atypical or abnormal pattern in the psychoses while it is known that slow activity is a common type of abnormal activity in the neurological conditions. There is, however, a great deal of overlapping rapid activity occurring in both neurological and psychiatric disorders (Table I and Fig. 3).

Among the psychoses rapid frequency cycles occur most commonly in the middle-age agitated depressions. It is a common type of atypical or abnormal pattern in the manic-depressive disorders where it occurs with about equal frequency in both the depressed and manic type. Rapid cycles, as has been pointed out previously by Gibbs(1) and by Finley and Campbell(4), are also found in schizophrenia.

Among the neurological conditions, it is perhaps of interest that rapid frequency cycles are most common in neurosyphilis(5) where we see symptomatology not dissimilar from that observed in some of the major psychoses. However, as already pointed out by Gibbs(1), these rapid cycles are seen in epilepsy, and in this study they have been encountered in other neurological disorders including advanced cerebral arteriosclerosis, migraine, encephalitis, and intracranial neoplasms.

Although I believe these high voltage rapid frequency cycles point to some form of neurophysiological disturbance within the cerebrum, the nature of the disturbance giving rise to them is not understood. The fact that these patterns are found in such a variety of clinical disorders does not simplify the problem. The fact that such activity develops in a certain percentage of individuals in the light stages of physiological sleep indicates that the normal functioning brain, under certain circumstances, is also capable of producing these rapid cycles.

TABLE I

Diag.	Cases	Per cent rap.	Quant.
Normals .....	300	3-8	+
Schizophr. ....	747	20-35	++
Man.-dep. psy. ....	89	25-40	+++
Invol. psy. ....	53	50-75	+++
Psychoneuroses ...	219	25-40	+
Psych. pers. ....	152	10-20	+
Epilepsy .....	626	10-25	++
Neurosyph. ....	200	40-55	+++
Br. tumor .....	70	5-10	++

The table illustrates the percentage of cases with high-voltage rapid frequency cycles in some of the more common neuropsychiatric conditions. The last column is a rough attempt to show the quantity of rapid cycles usually seen in the EEG. To illustrate: Case 1410 of Fig. 3 would be a 1-plus, C-1915 would be a 2-plus, and C-1643 and C-2050 would be a 3-plus quantity.

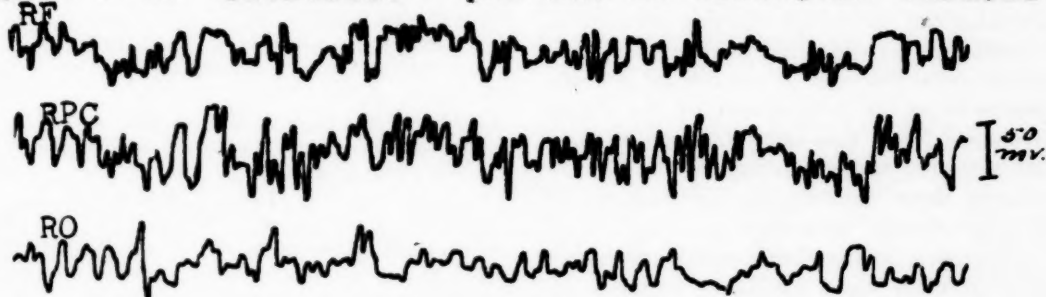
lied that rapid activity came from the superficial layers of the cortex, while the slow cycles originated from the deeper layers. Gibbs, Gibbs and Lennox(3), in their early studies on epilepsy, were the first in this country to call attention to them. They were so impressed by their occurrence during grand mal seizures and in some cases of grand mal epilepsy between attacks that they termed such patterns "grand mal activity." Early in this study, records were obtained mostly on patients with major psychoses. I was impressed by the common occurrence of these rapid frequencies in the manic-depressive conditions and in the middle-age "agitated depressions." Had I not already observed these patterns in a few cases of schizophrenia and neurosyphilis, and had I not

In certain instances these rapid cycles have some relationship to the degree of the underlying disturbance. For example, in the drug psychoses, rapid activity is more likely to result during the clinical stages of excitement or depression, while slow cycles are seen in the more advanced clinical stages of confusion and coma. This same transition

character of the pattern in increased intracranial pressure depends upon the degree of the pressure. In other words, the type of pattern one obtains, be it rapid or slow, would appear to be not so much related to the etiological agent or clinical diagnosis as upon the stage, degree, distribution or location of the lesion or lesions.

### SCHIZOPHRENIA (C. 2420)

Feb. 7-41 Catatonic - periods of emotional turmoil



Apr. 7-41 Improved - home on visit



FIG. 4.—Modification of an EEG pattern following clinical improvement in a catatonic schizophrenic with periods of emotional turmoil. February 7, 1941, during a period of emotional turmoil, and two months later, April 7, 1941, improved and home on visit. The first tracing (Feb. 7-41) shows a rapid frequency pattern superimposed upon normal and random slow cycles from the frontal and precentral leads. The second pattern after clinical improvement (April 7-41) shows an absence of rapid activity but persistence of irregular slow and normal frequency cycles with some traces of low voltage rapid activity.

has been observed in patients with neurosyphilis undergoing treatment. If a general parietic with confusion and loss of memory shows slow activity, following treatment the slow activity changes to rapid activity before returning to the normal (medium) frequency (5). Slow activity has been described as characteristic of increased intracranial pressure (6), yet I have seen similar cases in which 20 to 30 per second high voltage cycles were the predominant frequency from the entire cerebrum with only an occasional random slow cycle. Perhaps here again the

As has been noted above in reference to cases of neurosyphilis under treatment, the rapid cycles are not necessarily an irreversible feature of atypical or abnormal records (5). In some of the cases of manic-depressive psychoses, where we were fortunate enough to obtain tracings during and between their psychotic episodes, the rapid activity has been found to decrease or even disappear during the period of clinical remission. This has also been observed in a very few cases of catatonic excitement, as illustrated in Fig. 4. In this particular case, during the period

of catatonic excitement, the tracing contained rapid activity, some of which was superimposed upon irregular random slow activity. A tracing obtained while the patient was in remission and home on visit showed a pronounced decrease in the amount and amplitude of the rapid activity, while the slow activity persisted.

Although our present understanding of the significance of rapid frequency cycles does not permit us to state the character of the physiological disturbance giving rise to it, it does give us objective evidence of some physiological disorder of the central nervous system in 25 to 40 per cent of the major psychoses. It is also not too much to hope that a deeper understanding of the significance of these rapid cycles may help to fill the gap between neurology and psychiatry. Furthermore, in the electroencephalographic study of these rapid frequency patterns we may hope in time to gain a more thorough understanding of the biological side of the

personality problem. This would help to evaluate more objectively the equally important biological and environmental factors in the personality disorders.

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## EXPERIMENTAL CHRONIC "EPILEPSY" IN THE BABOON AND EPILEPTIFORM SEIZURES IN THE DOG, RABBIT AND GUINEA PIG<sup>1</sup>

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Recurrent convulsive seizures have been produced in the rhesus monkey by chemical and immunologic means(1). It was suggested by Dr. Heinrich Klüver that these studies be extended to include higher primates. Consequently, an African green monkey (*Cercopithecus aethiops sabaeus*) and a baboon (*Papio doguera*)<sup>2</sup> were selected as the only 2 species available to us at the present time. For comparative purposes dogs, cats, rabbits and guinea pigs were included as representatives of mammals with a less highly developed central nervous system.

The surgical procedure employed has been described previously(1). A circular disc containing the test material was inverted over the exposed motor cortex of the anesthetized animal and sutured in place. Unless otherwise indicated, alumina cream was the test substance employed in this communication.

*Baboon.*—Following operation on the left motor cortex, the baboon appeared clinically normal for a period of 7 weeks, despite repeated stimulation at weekly intervals. On 4 of the 5 succeeding days, clonic movements of the right arm and face, lasting for about 1 minute, were noted. These reactions were contralateral to the treated motor area. Thereafter, for a period of 18 days, generalized convulsive seizures, involving the face and all extremities, were observed at least twice each day when the animal was disturbed by feeding, cleaning the cage, or at times even upon opening the door of the room. (This baboon had always appeared timid, apprehensive and easily excited.) A typical seizure began with clonic movements

of the right arm and right side of the face; all extremities were soon involved in a generalized convulsion; and the animal fell to its side or back. The attack lasted approximately 1 minute. The baboon did not appear to lose consciousness, but looked groggy and made groping movements with its arms and legs in an attempt to right itself. On a number of occasions the animal went into an "epileptic rage," which was usually followed by a few more random clonic movements. Lack of muscular coordination and physical exhaustion persisted for approximately one-half hour.

Because of the severity of the seizures and the physical exhaustion which ensued, 2-4 grains (and occasionally more) of luminal sodium was fed daily for 1 month. During this time there was a reduction of one-third in the number of days upon which convulsions were observed, and the severity of the seizures was diminished. The administration of luminal was continued for several months, the daily dosage being gradually decreased to 0.75 grain. During 134 days of observations 27 seizures were noted and their incidence diminished progressively. No seizures occurred during the following 3½ months, even though luminal therapy was discontinued for the last 2½ months of this period. During the next month severe generalized seizures recurred without stimulation. These were observed on 5 occasions.

From this brief protocol it is evident that recurrent Jacksonian seizures were initiated 7 weeks after a single unilateral application of alumina cream to the motor cortex. These were soon followed by generalized convulsions with a variable degree of right-sided predominance. At the present time (1 year after operation) seizures still occur and appear to be of the same intensity as at their onset before luminal therapy was instituted.

*African Green Monkey.*—Alumina cream

<sup>1</sup> From the Department of Bacteriology and the Department of Research Psychiatry, New York State Psychiatric Institute and Hospital, New York, N. Y.

<sup>2</sup> We are indebted to Dr. Abner Wolf for this animal.

was applied over the right motor cortex. Since no effect was observed after 2 months, a similar application was made over the opposite motor cortex. Three weeks later (3 months after the first operation) clonic movements of the left arm and left side of the face were elicited upon stimulation. These Jacksonian seizures were evoked at will during the next 6 weeks. Eleven days later, after stimulation, a typical Jacksonian seizure of the left side was immediately followed by a similar attack on the right side, involving the arm, shoulder, and face for about 1 minute. This type of reaction was observed for the following 2 weeks. During the next 9 months only one attack could be elicited, although 2 apparently "spontaneous" seizures were observed.

From these data it is evident that recurrent convulsive seizures were induced experimentally in a baboon and an African green monkey. The clinical courses presented differences which fell within the range of variation previously observed in rhesus monkeys.

*Dogs and Cats*—For comparison, 6 dogs and 2 cats were prepared in a similar manner and observed over periods ranging from 2½-6 months. No convulsive seizures were elicited upon excitation. However, it should be noted that when a more active preparation of alumina, namely alumina A,<sup>3</sup> was employed in 7 additional dogs, violent contralateral and generalized seizures occurred from 6-24 hours after application. Four of these animals died; 2 overnight, and 2 after 1 week. Of the 3 surviving animals, 2 received 1-2 grains of luminal sodium, and none showed any further reactions for observation periods of 3 weeks in one case and 4 months in the remaining two. In 3 cats similarly treated with alumina A no convulsive seizures were observed. Two of these animals died after 1 and 5 days, respectively.

*Rabbits*.—The cortical application of alumina cream in rabbits yielded clinical results which have been reported (1), and may be summarized as follows: 5 of 7 rabbits remained negative, while 2 reacted after 3 and 4 weeks, respectively. The first of these, which had received active material

over each side of the brain in the frontal region, exhibited Jacksonian seizures of the arm and face on the right side during the first day of reactivity. On the next day convulsive seizures of the right arm, face, and leg were followed by involvement of the left side. The animal salivated profusely and died the same day. The second rabbit, which had been treated on the left hemisphere alone, exhibited contralateral Jacksonian seizures of the right face and leg. On the following day several similar reactions were observed. During the seizures the head was sharply twisted toward the right. Although stimulated periodically, no further reactions were elicited over a period of 4 months. Twelve additional rabbits served as controls, since the cortical application of inactive material, such as aquaphor alone, or in combination with various proteins, produced no clinical manifestations during an observation period varying from 6 weeks to 13 months.

*Guinea Pigs*.—In guinea pigs, alumina cream was injected intracerebrally rather than applied in discs, since the latter method offered surgical difficulties. In 8 animals a single dose of 0.1 ml was injected superficially into the brain of the frontal region of one hemisphere. Two animals died overnight, and 1 after one month. Clinical evidence of brain involvement in the 5 survivors occurred 2-4 weeks after injection. One exhibited generalized convulsions after 3 weeks and died the same day. The type of response common to the other 4 animals consisted of rapid, laterally directed, oscillating movements of the head and trunk. Additional features, observed in some, included definite epileptiform attacks with somersaulting, and varying degrees of unilateral paresis in the limbs opposite the site of injection, associated with apparent loss of balance. One of these died the same day after cardiac bleeding, while the remaining three died 5, 8, and 16 days after the onset of the attack.

Since these animals succumbed so rapidly, additional guinea pigs were treated in a similar manner with smaller amounts of alumina cream. One volume of alumina cream was mixed with the following volumes of saline and 0.1 ml of the resulting suspensions in-

<sup>3</sup> Obtained through the courtesy of Dr. Harry Sobotka.

jected: (a) one volume—9 pigs; (b) two volumes—4 pigs; (c) four volumes—4 pigs; (d) nine volumes—6 pigs. Positive reactions were observed in group (a) only. Six of the 9 animals remained negative, while 3 reacted four weeks after injection. One exhibited slight oscillatory movements of the head and trunk and died the following day. The other two showed the same clinical signs as described above in the cases where undiluted alumina cream was employed. The striking feature, however, was the fact that these reactions could be elicited at will by a sharp noise or by handling, and recurred for more than 2 years (to date) in one animal, the other one having been sacrificed for histopathologic study after 4 months of chronic reactivity. A recent neurologic examination of the survivor revealed hyperactivity of the entire side and limbs contralateral to the site of injection. The convulsive manifestations did not appear to be the result of vestibular involvement. The pathologic findings in the other guinea pig were essentially the same in type as those previously reported in monkeys, except that the reactive process in the meningocortical structures of the injected site, while not as marked, was more acute.

#### DISCUSSION

Acute and chronic convulsive seizures can be produced in a number of animal species by a single cerebral application of hydrous oxides of aluminum and other substances. Experimental recurrent seizures in animals are of special interest since they may contribute to the understanding of the mechanism involved in human epilepsy.

Following treatment with alumina cream, the "higher" types of animals studied, namely the baboon and the African green monkey, showed reactions comparable to those previously reported(1) in a large series of rhesus monkeys. Dogs and cats failed to respond. In the rabbit convulsive manifestations occurred after the usual clinically free period, but were of short duration (1-2 days). In the guinea pig, although the application of alumina cream was by intracerebral injections, a clinically free period likewise preceded the onset of seizures. These

were either acute or chronic in type. In the latter, the convulsive manifestations were mass movements in the sense that they involved the entire body and were not confined to special muscle groups as was observed in a rhesus monkey treated by intracerebral injection.

In contrast to the reactions induced by alumina cream, which invariably followed a clinically free period, those resulting from alumina A appeared within 24 hours of application, and subsided within a few days (in dogs) and after a week (1 monkey) usually after treatment with luminal sodium. No seizures were observed in 3 cats similarly treated, 2 of which died within 5 days. No further seizures were observed in the dogs. However, in the monkey, after a clinically free interval of 7 weeks following the initial reaction, seizures recurred and have continued to the present time (2 years).

The effectiveness of alumina cream in producing recurrent convulsive seizures is most striking in the primates. The mechanism by which this substance exerts its action remains obscure, but from the results of histopathologic(2) and electroencephalographic(3) examination, it would appear that the anatomical alterations found failed to account for the electrophysiologic disturbances recorded in the electroencephalogram. Chronic convulsive reactivity has been produced only by oxides of aluminum, but not of iron or magnesium. (Cupric hydroxide and silver oxide caused immediate acute seizures of short duration with resulting paralysis.) The properties of alumina cream which might account for its activity in this connection, such as its amphoteric nature, adsorptive capacity for proteins, and its possible rôle as a cell irritant or poison, require further study, particularly in comparison with other related and unrelated substances. This is now in progress.

It is evident from this and previous studies that alumina cream produced recurrent convulsive seizures with regularity in the primates, but only infrequently in the lower animals. This may have depended upon the nature and dosage of the test substance employed, the method of application and the site selected, or species differences involving

the structure, function and integration of the cerebral cortex.

#### SUMMARY

Experimental chronic "epilepsy" has been produced in the baboon and African green monkey by a single application of alumina cream to the motor cortex. After a clinically free period, reactions first occurred 7 weeks and 3 months, respectively, after operation. These observations parallel the results obtained previously in a large series of rhesus monkeys.

Rabbits similarly treated reacted 3-4 weeks after operation with acute convulsive attacks of short duration.

Recurrent epileptiform seizures were induced in the guinea pig following an intracerebral injection of the same material. The convulsive pattern differed from that ob-

served in the primates. Dogs and cats failed to respond to the cerebral application of alumina cream. However, alumina A caused immediate acute convulsions in dogs, but produced no seizures in cats.

#### ACKNOWLEDGMENT

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## THE CONTRIBUTION OF PSYCHIATRY TO PSYCHOANALYSIS<sup>1</sup>

LEO H. BARTEMEIER, DETROIT

On the occasion of this one hundredth year of American psychiatry and this thirty-fifth year of American psychoanalysis, it seems appropriate to review, at least briefly, the influence of the parent discipline on the growth and development of psychoanalysis in this country. This growth and development has been more extensive and more wholesome than that which has taken place in Europe. I say more wholesome quite advisedly for the isolation and the alienation from medicine which has always marked the history of psychoanalysis, and to a lesser extent the history of psychiatry itself, has been much less pronounced and persistent in this country than it has been abroad. Psychiatry, and particularly American psychiatry, has exerted the most favorable influence in diminishing this isolation and in establishing psychoanalysis as a medical discipline.

It is common for people to point out the contributions of psychoanalysis to psychiatry and so much clinical work has been done that it is now incontestable that psychoanalysis has contributed very richly. The title of my paper has been formulated deliberately because what psychiatry, and particularly American psychiatry, has contributed to psychoanalysis has apparently never been discussed in the literature. Yet that psychiatry did have much to contribute to psychoanalysis was clear in Freud's mind, so much so that in 1916 he had the following to say when he was discussing the limitations of psychoanalytic therapy in the narcissistic disorders and in the psychoses: "Our psychiatrists do not study psychoanalysis and we psychoanalysts see too little of psychiatric cases. We shall have to develop a breed of psychiatrists who have gone through the training of psychoanalysis as a preparatory science" (1). This comment and this recommendation is even more applicable today than it was at the time Freud made it. The present world

conflict has clearly demonstrated that one of the great needs of our time is a much larger number of psychoanalytically trained psychiatrists and psychoanalysts. To his statement in 1916, Freud added the following remarks: "A beginning in this direction is being made in America, where several of the leading psychiatrists lecture on psychoanalytic doctrines to their students, and where medical superintendents of institutions and asylums endeavor to observe their patients in the light of this theory" (2). This statement by Freud may well recall to us Albert Barrett, the director of the first psychiatric university hospital who, in addition to his achievements in neurological research and his contributions to the problem of heredity from 1906 was studying the schizophrenic material in his clinic in the light of psychoanalytic theory and was lecturing on psychoanalysis to his university students.

The recrudescence of psychiatry and the actual short time existence of psychoanalytic thinking require an at least historic orientation if one is to undertake any serious evaluation of that which psychiatry has contributed to psychoanalysis. Although some are familiar with the following facts it is perhaps not generally known that Freud's estrangement from his medical colleagues antedated his discoveries in psychoanalysis by several years. As early as 1886 when he demonstrated a case of classical hysterical hemi-anesthesia in a man before the Vienna Medical Society the medical authorities expressed their intolerance by excluding him from the neurological laboratory and by preventing him from giving his customary lectures. Some years later, when he presented the results of his clinical observations on the part played by the sexual factors in the etiology of the neuroses before the Vienna Neurological Society his addresses were received with a chilly silence and his estrangement from his medical confrères became complete. This latter event marked the beginning of a thorough alienation between

<sup>1</sup> Read at the Centenary Meeting of The American Psychiatric Association, joint session of the Section on Psychoanalysis and the American Psychoanalytic Association, Philadelphia, Pa., May 15-18, 1944.

medicine and psychoanalytic theory. We have it in his own words that for more than ten years Freud had no followers. He was completely isolated. In Vienna he was shunned, while abroad no notice was taken of him. His *Interpretation of Dreams* published in 1900 was scarcely reviewed in the technical journals.

We cannot overlook the fact that the history of the first decade of psychoanalysis was marked by this complete cleavage and that it was not until after the turn of the century that a small group of Swiss psychiatrists came to accept Freud's theories and began to apply them to their patients. It is noteworthy that these psychiatrists were quick to utilize psychoanalytic theory in the investigation of the psychoses and in their psychiatric work. Freud recognized these first contributions from psychiatry to psychoanalysis when he wrote that "the Swiss were by no means mere recipients. They had already produced very creditable scientific work, the results of which were of service to psychoanalysis" (3). Freud outlined three contributions from the Zurich school of psychiatry. The first was the utilization of the association experiments which "made it possible to arrive at rapid experimental confirmation of psychoanalytic observations and to demonstrate to students certain connections which the analyst would only have been able to describe to them" (4). The second contribution which Freud regarded as of far greater importance was made by Bleuler who "showed that light could be thrown on a large number of purely psychiatric cases by reference to the same processes as have been recognized through psychoanalysis to obtain in dreams and neuroses" (5). The third contribution which Freud regarded as having minor significance was "the theory of complexes which grew out of the Diagnostic Association Studies" (6). These quotations from the *Collected Papers* are of interest because they show that Freud regarded the application of his theories in purely psychiatric cases as a most important—his word—contribution from psychiatry to psychoanalysis.

While it is true that from 1902 onward psychoanalysis came to be accepted by many workers in various parts of the world, it

remains a fact that up to the outbreak of this last world-wide conflict, European psychoanalysis still went its own way. There were psychoanalytically trained psychiatrists here and there in European teaching institutions like Schilder and later Hartman in the department of psychiatry in Vienna or French psychoanalytically trained psychiatrists in St. Anne in Paris under Henri Claude but these were the rare exceptions. In America, on the other hand, psychoanalytically trained psychiatrists served in a number of psychiatric hospitals as well as in various teaching institutions, and The American Psychiatric Association is the only psychiatric association in the world which boasts a section on psychoanalysis. The isolation which characterized European psychoanalysis was not repeated in this country partly because the pioneers in American psychoanalysis regarded their newly acquired specialty as a branch of medicine and continued to function as physicians and psychiatrists. Among these, the leadership of Dr. Brill has been the most powerful influence in shaping the course of psychoanalysis in this country. He has always vigorously maintained that psychoanalysis is a part of psychiatry and he expressed himself very clearly about this during his discussion of a paper by Trigant Burrow in 1926 on the Need of an Analytic Psychiatry. On that occasion in his characteristic way, Dr. Brill said: "I feel that psychoanalysis is really very much related to psychiatry. In fact, it is only a part of it. Psychiatry is the all-inclusive mental science just as is medicine, in the broad sense, and psychoanalysis can no more be detached from psychiatry than can histology or pathology from medicine" (7). I have cited this statement by Dr. Brill because it typifies an orientation which has been of great benefit to both psychiatry and psychoanalysis in that it has encouraged collaboration in research and therapy and discouraged the tendency toward isolationism. This orientation has been repeatedly emphasized, for example, by Lionel Blitsten in his lectures and in his clinical demonstrations of techniques. It has been well documented by Karl Menninger particularly when he wrote that

In their capacity as therapists—psychoanalysts are, by definition, psychiatrists—or at least they are

to this extent practicing psychiatry. We officially acknowledge this fact and claim to be physicians and psychiatrists. Yet there is a certain ambiguity, not to say ambivalence, about the psychiatrist-psychoanalyst relation somewhat akin to the physician-surgeon relation. Surgery is a technique requiring special training, and when we speak of surgeons we do not forget that they are primarily physicians. No good surgeon ever forgets it. Nor should any good psychoanalyst ever forget that he is primarily a psychiatrist. If, for practical purposes, we sometimes speak of psychoanalysts and psychiatrists, we should always remember that this is a logical inaccuracy, just as is the expression physicians and surgeons(8).

Recalling these remarks, one may now well ask what is the basis for discrimination between psychiatry and psychoanalysis and one can answer immediately that there is no adequate basis for such a discrimination in many instances. There are, however, psychoanalysts who have not recognized the importance of good psychiatric training and who manifest no feeling of closeness to the science and art of psychiatry, if in fact they think of themselves as physicians—and there are psychiatrists who still entertain such vigorous prejudices that they would resist any opportunity to discover any facts about psychoanalysis, just as they would avoid any opportunities for intellectual exchange with physicians in neighboring fields. Some of these last mentioned show avoidance to psychoanalysis exclusively: in many of them, however, there is a suggestion of a professional isolationism.

Freud's recollection of his visit of Worcester in 1909 cannot be overlooked because it vividly portrays the contrast between the friendly way in which his addresses were received by his American audience and the bitter opposition and alienation he felt from his European colleagues. In his autobiography Freud described these contrasting situations in the following manner:

At that time, I was only fifty-three. I felt young and healthy and my short visit to the new world encouraged my self-respect in every way. In Europe I felt as though I were despised, but in America I found myself received by the foremost men as an equal. As I stepped on to the platform at Worcester to deliver my Five Lectures upon Psychoanalysis it seemed like the realization of some incredible day-dream: psychoanalysis was no longer a product of delusion; it had become a valuable part of reality(9).

This statement is particularly potent when we remember that Freud was not exactly prejudiced in favor of America. It has, in addition, far greater significance. The receptiveness of those gathered at Worcester to hear the first lectures on psychoanalysis was but the first sign of the way in which psychoanalysis was to be accepted and fostered by American psychiatrists. It is a matter of record, for example, that psychiatrists like Macfie Campbell, Ross Chapman, August Hoch, George Kirby, Adolf Meyer and William A. White were among the founders of the American Psychoanalytic Association. It is a well-known fact that the energetic interest and cooperation of these and other leaders in psychiatry with psychoanalysts like Brill, Coriat, Jelliffe, Oberndorf, Jones and Taneyhill provided the original impetus for the growth and development of psychoanalysis in this country.

One may now ask what has come of the subsequent efforts at collaboration of psychiatry and psychoanalysis and what has come to psychoanalysis of relatively independent developments in psychiatry. Perhaps this is an unjustifiable abstraction or separation but at least we know that some psychiatrists obtain psychoanalytic training to facilitate their institutional work; that many psychiatrists practicing outside of mental hospitals have sought psychoanalytic training to make their therapeutic efforts more effective and that some psychoanalysts have been sought as such for additions to mental hospital staffs to apply their knowledge and skills to the problems of the psychoses. All these represent collaboration. We know that some workers, properly classed as trained psychoanalysts, have concentrated on psychiatric enquiries without more than instrumental use to their psychoanalytic equipment. Among these, for example, the contributions of Harry Stack Sullivan to the problems of schizophrenia and the investigations by Gregory Zilboorg into the dynamics of the postpartum psychoses are representative of the relatively independent investigations, which have been neither for nor against psychoanalysis, but which like all productive work have made for progress. We also know that there has been a great deal of data collected at the Henry Phipps Psychiatric Clinic with-

out any primary idea of utility to psychoanalysis or cross fertilization, yet the dynamic psychiatry of Adolf Meyer and his pupils has contributed much to the wider acceptance of psychoanalysis. The diligent, respectful and scholarly efforts of Dr. Meyer personally to clarify issues and to focus problems in discussions bordering on psychoanalytic psychiatry have been all too often overlooked in tracing the origin of fortunate developments in psychoanalysts. Dr. William A. White has unusual significance among American psychiatrists who contributed to the growth and development of psychoanalysis and to the enrichment of psychiatry by psychoanalysis. Fluent, immensely persuasive, eternally the teacher, Dr. White discouraged on every occasion the violently prejudicial opposition which was directed here and there at the views of Freud. With Smith Ely Jelliffe he founded *The Psychoanalytic Review* in 1913 which he edited to the time of his death. Through this Quarterly and by dint of innumerable articles and discussions he simply compelled the more serious of his colleagues to see that the dynamic theories gave a great deal to their psychiatry.

A survey of the influence exercised by psychoanalytic theory on custodial practice cannot be undertaken here. This would properly expand beyond the confines of the mental hospital and explore the field of penal and reformatory efforts—the field in which Bernard Glueck exercised a potent and benevolent influence. It is more germane to my topic to consider briefly the various contributions of institutional psychiatry to psychoanalysis which have scarcely ever been described as such in the literature. While time does not permit anything like an adequate survey, we know, for example, that psychiatrists like William A. White at St. Elizabeth's, Arthur H. Ruggles at Butler, Mortimer W. Raynor at Bloomingdale and Ross Chapman at Sheppard-Pratt were always encouraging the use of psychoanalytic theory for research and therapy in the psychoses. In these hospitals, the psychoanalysts were given opportunity to draw upon psychiatric material which deepened their insights into the nature of ambulatory neurotic patients. In these hospitals more forward

looking members of the staff were encouraged to undergo psychoanalytic training. We also know that Dexter Bullard at Rockville and Karl Menninger at Topeka have oriented the treatment of psychotics and those suffering from severe character disorders requiring intramural therapy to a practically exclusive psychoanalytic procedure. From these institutions and from a number of others modified techniques and a wealth of clinical data have been contributed which the average psychoanalyst, sentenced as it were from the beginning to private practice only, could not have achieved.

We can be eternally grateful for these gifts from institutional psychiatry. It would be well if we more often appreciated another gift along these lines. The clinical judgment and sureness which the treatment of any patient occasionally requires is best gained by adequate institutional training. Insofar as the training is adequate and effective it would clearly seem to be the greatest contribution that psychiatry makes to psychoanalysis.

The official recognition and acceptance of psychoanalysis by The American Psychiatric Association by the creation of this section on psychoanalysis has provided an annual forum for collaboration which has been of value to psychoanalysis as well as to psychiatry. The first meeting of this section was a symposium on the relationship of psychoanalysis to psychiatry. What was said on that occasion by the chairman, Dr. Brill, in his introductory remarks, and by Dr. George H. Kirby in his presidential address to The American Psychiatric Association, is well worth recalling on this tenth anniversary. These statements are as applicable today as they were in 1934. Addressing the membership of The American Psychiatric Association and speaking in behalf of American psychoanalysis Dr. Brill said:

We bring you this symposium on the relationship of psychoanalysis to psychiatry to mark the beginning of the new era in the history of psychoanalysis in America which you have thus initiated. . . . To us who have been long and intensively occupied with psychoanalysis, this official recognition is the realization of a cherished dream. For psychoanalysis in this country, your action means not alone recognition by the greatest body of psychiatrists in existence, but also the admission of psychoanalysis to the guardianship of an environ-

ment most suitable for the development and refinement of our valuable scientific and therapeutic tools. In your midst, we feel at home. Here we can exchange views and clinical experiences beneficial to all of us. Here, if necessary, you will exert control and check any luxurious but perhaps unhealthy excrescences that are prone to sprout forth in any rapid new growth. Here, we are where we belong, for psychoanalysis belongs to psychiatry. Let there be no quibbling about it; psychiatry is its birthright (10).

Does not this large audience, as all the great audiences that have honored this joint meeting each year, affirm his wisdom? Psychoanalysis is a child of psychiatry. It is no exaggeration to say that it is the precocious child in this scientific family. Such a child is always difficult to raise and needs special guidance. This is as true in scientific developments as it is in the home. The leaders in American psychiatry who have recognized the value of psychoanalytic theory have provided this needed direction and socializing influence.

When the then president of the Association, Dr. George H. Kirby, referred to the formation of this section, he mentioned "some psychoanalysts who," as he said,

have sought to show that psychoanalysis has more important and more fundamental connections with other branches of science than with medicine or psychiatry. They look upon psychoanalysis as occupying a more exalted position as a basic science of the mind, one which will ultimately furnish knowledge on which a future psychiatry will be built. To many, this seems rather strange in view of the fact that psychoanalysis originated from knowledge developed during the treatment of mentally

sick persons and practically all of its later important contributions have been made by physicians with psychiatric training working on clinical case material. This desire to keep psychoanalysis separate from medicine as a special science or cult and at the same time to encourage lay people to treat patients by analytic methods has done much to create suspicion in the medical profession and to arouse resistance against psychoanalytic doctrine. . . . Our goal should be to draw psychiatry and psychoanalysis into closer relationships and to identify them both more positively with the practice of medicine (11).

Are we not today all the more ready to reaffirm these views?

Let me add only the thought that American psychiatry's contribution to psychoanalysis has been far more than an idealistic responsiveness. American psychiatry has remedied psychoanalytic seclusiveness and has consistently accepted psychoanalytic investigation and therapy as an integral part of psychopathology, psychiatry and medicine as a whole.

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## INDUCTION PSYCHIATRY

### A REVIEW AND SUGGESTIONS

MAJOR H. H. GOLDSTEIN AND CAPTAIN W. ROTTSMAN, U. S. A.

After almost three years of inducting men into the service, it would seem desirable at this time to review the relationship of psychiatry to the problem of selecting men for service.

Probably more steps were taken by the psychiatrists in facing the problem of rejecting men unsuitable for military service than by any other specialty group. Suggestions as to procedure were made at various committee meetings. Among the more common suggestions were those relating to the obtaining of social service histories, the length and type of examination and the number of men to be examined by the individual psychiatrist.

Suggestions for the psychiatric and neurologic examinations showed some variation, but recommendations by most writers were more or less the same (1, 2). The psychiatrist was looked upon as the examiner to determine the ability of the individual to adjust to the strain of military life and was expected to evaluate the total person (3, 4, 5, 6, 7, 8, 9, 10,).

The information relative to technique of examination may be summarized as including the following recommendations: 1. Position of neuropsychiatrist as the last examiner in the team. 2. Use of a private cubicle. 3. Utilization of observations of previous examiners. 4. The method of interrogation suggested seemed to have general agreement among the examiners, and was chiefly based on developing symptom complexes of syndromes by further questioning after the patient had given a significant answer to a key question. As an example, a patient stating that he had gone to the third grade in school would be further interrogated as to failures, particularly difficult scholastic subjects, age at which school was terminated, etc., followed by some questions to rapidly ascertain mental level. The questions generally used as the key for further follow up were more or less similar throughout the

country and apparently adopted with no previous collaboration with other examiners. A standard type of verbal questionnaire seemed to be developed which was almost alike for all stations, and, of course, was based on detecting the commonly recognized psychopathic behavior patterns. Some of the questions were—

1. How is your health? How do you feel, etc.?
2. How far did you get in school? At what age did you leave school?
3. What kind of work do you do? How long have you done it?
4. Have you ever had fits, spells, etc.?
5. How many times have you been arrested?
6. Are you married? What do you think about the girls, etc.?
7. Do you wet the bed at night?

The patients' answers would lead to information, which would be calculated to determine fitness for service.

Neurological examinations were suggested which included such standard observations as: gait, Romberg, pupils, reflexes, etc.

The time element per examination was obviously an important one as was the number of men to be examined. There seemed to be some variance as to what constitutes sufficient examination to determine fitness for service. Estimates usually ranged from 5 to 15 minutes per patient, with the upper limit suggested as a desirable length of time to spend on questionable cases. There seemed to be unanimity as to the number of men to be examined per psychiatric interview, 50 to 75 men being almost unanimously agreed upon. For some stations, a check system of rejections was considered desirable, the inductee being rejected only after the original opinion was supplemented by that of another psychiatric examiner.

Rejection rates did not show any uniformity. Early reports indicated attempts to break the rejections down into the component types. As an example, Aita (11) in 242 rejections

made at Ft. Snelling prior to the declaration of war, found the following percentile causes for rejections:

	Per cent
Mental deficiency .....	38
Psychopathic personality .....	5.8
Mood disorders .....	5.4
Psychoneurosis .....	17.3
Schizoid and paranoid states.....	11.5
Chronic alcoholism .....	2.5
Neurologic conditions .....	18.6

Occasionally some stress was placed on evaluation of the individual by aggregating the unfavorable features. As examples, Aita mentions: "the older man, divorced, a somewhat heavy drinker, with varicose veins and myopia would obviously have the score weigh heavily against him if there was some doubt as to his adjustment to military life."

The problem of effect of the monotony and routine character of the work on the examiners was not overlooked. Constant daily repetition of induction work was found to be fatiguing and the efficiency of the examiner decreased as the end of the examination line was approached, thereby influencing his rejection tendency. A considerable variation in the ability of individual examiners to evaluate the inductee in a short period was likewise noted and a wide range of backgrounds were to be found among the men who were expected to carry out induction psychiatry both as to previous training and experience and also the variability in the procedures of the subspecialties of psychiatry. The examiners were drawn from private practice, state hospitals, university departments, child guidance clinics, psychoanalytic institutes, veterans hospitals, etc. Each group was naturally influenced by its previous activities. It was suggested that there was as much need to examine the examiner as there was to examine the examinee.

Suggestions for the determination of mental deficiency and the elimination of defectives centered around the development of some scheme which would suggest the presence of a defective. The Kent ten-minute oral examination and a simple arithmetical examination, the digits forward examination and other similar short form examinations received variable recognition. A psychologist was available at some stations for more comprehensive testing. The difficulty with using

printed material because of the frequency of language difficulty and educational poverty made general testing by self-administered tests impracticable. The institution of literacy tests made it possible to eliminate most defectives prior to examination by the psychiatrist. No clear cut level of mental age as used in the Binet test seemed advisable. Clinical judgment and later the literacy tests plus clinical judgment were more important in determining the desirability of inducting a draftee.

Generalities as to determination of a man's fitness for service were commonly expressed at first. Such statements as—"the major criterion has been that a man should be excluded if he presented a greater than average risk of breaking down under the strain of army service"—were often made as basis for rejection. Obviously many of the men had formulated in their minds the groups of signs and symptoms warranting rejection but these were not generally so expressed that an individual with little or no previous experience could grasp the factors considered as combining into a disqualifying defect. Where is the line between gastric neurosis and gastric distress which decides presence or absence of a rejectable neurosis?

Checking the results of induction station psychiatry was attempted by some induction station psychiatrists without any definite correlating agency establishing the cause for separation from service and actual numbers separated. Aita(11) suggested a follow-up study of 1000 consecutive cases in which the possibilities of psychiatric disability were to be carefully noted at first, and the men then observed during their military service. Bloomberg(12) made a study of corps area CDD discharges which he felt gave rather conclusive evidence of the efficiency of a well staffed induction unit as compared to one not having sufficient psychiatric help.

The actual operation of the induction station differed considerably from that envisioned in original plans.

Social service and other records were made available at some stations but usually such service was limited to a few induction stations in large cities. There was practically no organization for obtaining information about inductees in by far the largest number

of stations. Probably aside from the few large cities where histories were made available the tendency was for the draft boards to send negative reports. Usually such reports indicated that in the opinion of the draft board the named selectee was malingering and that the various members of the board knew the selectee and knew that he was in good health. The references to development of a system for cooperative activity between welfare agencies, schools, penal institutions, etc., if any, are probably to be found in those localities in which some adequate arrangement could be made. A general plan covering the possibility did not seem to take shape. The psychiatric examiner was apparently able to attain the goal of being the last examiner on the team, of using a private cubicle and of having the advantage of previous examiners, but apparently there was not a complete uniformity of these advantageous possibilities. The evaluation of, and the value of previous examiners' findings quite naturally varied with the men on the team and length of time available for examination. The method of interrogation and the questions used were reasonably uniform, but evaluation of responses and ability to follow through to definite conclusions varied so much that many doubts arose as to the grounds upon which inductees were being rejected. Neurologic examination varied from attempts to do a 3 to 5 minute neurologic evaluation to none at all other than the obviously recognized neurologic defects.

The recommendations as to time sufficient for each examination were soon found to be without hope of achievement. Although some stations, usually in large cities, had enough examiners to warrant a 3 to 10 minute examination, many and probably most were not as fortunate.

Rejection rates for stations based on statistical reports showed that no reliable inferences as to rate of rejection could possibly be made. Enuresis might be statistically included with the genito-urinary cases in some stations or with the psychiatric in others. If more than one diagnosis calling for rejection was made one station might include the rejection under one, the other station under a different category. The same unreliability was present in statistics as to cause for rejection

in the various psychotic groups. Some stations might have highly reliable criteria for psychiatric diagnoses, others were satisfied with indicating any rejectable cause.

Generally there were several factors contributing to a wide variance of individual psychiatric interest. As has been mentioned, the varied backgrounds of the examiners was one factor. Other problems relating to the individual psychiatrist on the induction team that might be mentioned are:

1. The attitude of chief medical examiner and other induction station officers to the psychiatric problems.
2. The attitude of the draft boards, community, etc., to the psychiatric rejections.
3. The morale of psychiatrists as influenced by being kept at a monotonous position for years while new men being brought into service frequently were placed in positions having a lesser degree of monotony, promotions and other similar factors.

To meet some of the deficiencies of recruit examinations, the navy, by instituting a special neuropsychiatric program with methods for rapid disposal of psychiatric disabilities to a large extent overcame the deficiencies of the induction station examination.

The writer, in making certain recommendations, recognizes that administrative conditions might make such suggestions impracticable but feels that such administrative difficulties as do exist would be well worth overcoming to bring about an increased efficiency in induction station psychiatry.

All personnel selected for this work should receive a period of training with special reference to rapid formulation of reasons for rejections based on rather specific groups of items to be discussed later. The personnel should be as evenly distributed as possible so that a more or less uniform number of patients would be examined by each psychiatrist at all stations. This could be accomplished by transfers and procurements from civilian life. There is no logical reason for one station to be operating with one psychiatrist examining 500 men daily while another station has 10 to 15 psychiatrists assigned to the same task. The expected quotas for

each board could be examined by a central agency which could assign "roving" psychiatrists to the units especially in need of men. All personnel should be examined at intervals to determine whether any pronounced change in their attitude has occurred with regard to causes for rejections. Changes in induction station personnel should be made at yearly intervals or thereabouts by exchange with men situated in nearby hospitals. Where possible, as in induction stations associated with hospitals, a rotating service should be instituted permitting induction station psychiatrists to be rotated into hospitals and vice versa. Opportunities for promotion should likewise be present.

The help which could be given to the psychiatric examiner by having available records from social service, school, institutional welfare and other agencies must of necessity vary with the community but a central coordinating unit should set up a standard procedure for such station, depending on the local situation. The complexity of the task, the number of individuals to be employed, etc., makes such a central activity impracticable, except as an aid to local communities willing to accept the burden of organization and development of a successful program. One example of the possibilities for a community with limited facilities could be as follows:

A volunteer or hired worker could be responsible for sending a questionnaire to each agency in the community; receiving and sorting the questionnaires and forwarding those of significance to the induction station. The names of all men to be called for induction could be given to the worker two weeks in advance and separate questionnaire then sent to the school principal, sheriff, county agent, county hospital, etc., each questionnaire being so worded as to yield pertinent psychiatric data. The worker on receiving the questionnaires, would transfer the information to a basic record sheet covering all the agencies and forward all those with pertinent data to the induction station.

At the induction station, the following plan could be developed:

1. Administrative and educational causes for rejections would tend to help eliminate

psychopathic personalities and mental defectives, the draftee being first considered for possible rejection under these categories.

2. Further elimination would be made upon the following:
  1. Psychiatric questionnaire.
  2. Rorschach group screening test.
  3. Minnesota multiphasic personality test—or a modification of this test.
  4. Organic disease questionnaire.
  5. Psychiatric interview.

An example of a psychiatric questionnaire is the following which has been employed successfully at the Ft. McPherson Induction Station.

Question	Answer			
	Excellent	Good	Fair	Bad
1. How is your health?				
2. Do you suffer from any nervous conditions?			No	Yes
3. Have you ever had a nervous breakdown, been treated in a hospital for nervous disease, a state hospital or sanitarium for nervous patients?			No	Yes
4. Do you visit doctors about your health very often?			No	Yes
5. Do you find you must be away from work often because of sickness?			No	Yes
6. Have you ever had a military discharge?			No	Yes
7. Have you ever had fits, epilepsy, convulsions or spells of unconsciousness?			No	Yes
8. Is there nervous trouble or insanity (crazy) in the family?			No	Yes

In all, 24 questions are asked. The arrangement permits rapid spot checking and some evaluation as to diagnosis of the psychiatric disability.

The entire group is further tested by the use of the group Rorschach. Harrower-Erickson(13) has adequately described the technique. By the group method the ink blot is projected on a screen and the person viewing the test is required to choose one of ten possible impressions. In this manner several hundred men can be tested at one time. As a third group test the multiphasic personality schedule (Minnesota)(14) could be used to further separate possible rejectable draftees. A series of slides, each containing 20 questions is thrown on a screen at intervals. The draftee answers "true" or "false" or "cannot say" on a sheet having the questions numbered consecutively and containing a check square for the proper answer.

The multiphasic test has been standardized to give a reasonably reliable diagnostic index on the basis of response to 504 items stated in simple language and requiring an answer in one of the three categories mentioned.

The use of an organic disease questionnaire would aid in the elimination of organic disease, and at the same time indicate possible psychogenic disease. This questionnaire could be so arranged that all the disabilities mentioned in MR 1-9 would be covered by blocks of questions requiring a yes or no answer, the terms being of course modified according to the examinee's knowledge of disease.

All papers would be checked by a group of enlisted men and the potential psychiatric rejects separated from the potential non-rejectable. A suggested rejection system based on the following criteria would then be used.

1. Most "negative malingerers"—epileptic, psychopathic, etc., would tend to be recognized on the poor Rorschach score with excellent questionnaire responses.
2. Psychotics would be rejected upon
  - (a) Positive social service report alone. (Institutionalization, psychiatrist report, etc.)
  - (b) Social service report plus a positive questionnaire, suspicious Rorschach and multiphasic test.
  - (c) A positive questionnaire, suspicious Rorschach and interview suggesting psychoses.
  - (d) Strongly suspicious Rorschach in absence of confirmatory interview.
3. Psychoneuroses would be rejected on
  - (a) Very positive social service information, *e.g.*, medical work and social history.
  - (b) Positive social service history plus suggestive or positive rejectable Rorschach and multiphasic tests and psychiatric interview.
  - (c) Very positive Rorschach rejectable score and a psychiatric interview tending to confirm findings.
4. Psychopathic personality would be rejected on
  - (a) on Social service history alone when definitely indicative.
  - (b) on Questionnaire responses plus a suggestive or positive rejectable Rorschach or multiphasic test and interview.

There is no need in this paper to further indicate the development of criteria for rejection. Further breakdown of criteria into special symptom groups which are rejectable is possible.

On the basis of the described examination plan, the following would be accomplished:

1. A rapid index of evaluation of possible psychiatric disabilities could be established with comparable criteria for rejections being laid down for each station.
2. Even in the absence of sufficient help, excellent screening could be accomplished.
3. Statistical evaluations would be enhanced by establishment of criteria for rejections applicable to all stations.
4. The entire method is possible of accomplishment with little increase in personnel and a short increase in time.
5. The method is suggested as a routine procedure for examining all men for overseas service and as a screening examination in demobilization.
6. Marked improvement in the examination for organic defects would result with a decrease in the number of physical rejectables being accepted.
7. A more thorough evaluation of the total physical and mental status would be possible.
8. The objectivity of the cause for rejections would lead to a better acceptance of psychiatric rejections by draft boards and public.

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# PROCEEDINGS OF SOCIETIES

## THE AMERICAN PSYCHIATRIC ASSOCIATION

### PROCEEDINGS ONE HUNDREDTH ANNUAL MEETING

HOTEL BELLEVUE STRATFORD, PHILADELPHIA, PA.

MAY 15-18, 1944

#### MONDAY MORNING SESSION

MAY 15, 1944

The One Hundredth Annual Meeting of the American Psychiatric Association was called to order by the President, Dr. Edward A. Strecker, at 9.45 a. m.

THE PRESIDENT.—It is my great honor and privilege to call to order the Centenary Meeting of the American Psychiatric Association—I might say an honor which is unlikely to fall to any of our present living members!

The meeting will receive its invocation from the Reverend Frederick R. Griffin, Pastor, First Unitarian Church, Philadelphia.

REV. FREDERICK R. GRIFFIN.—We turn unto Thee, Almighty God, invoking Thy blessing upon this centennial meeting of enriching memories and compelling hopes that the work which was begun in faith may be continued with enlarging knowledge and perfected skills.

Thou hast endowed our lives with various gifts. May they be so used that Thy Name shall be glorified, our fellow men served, and the adventure of life made more honorable and dignified.

Thou hast given unto some the gift of discernment of the ways and mysteries of the human mind. Prosper them in their work. Prosper them for the healing of the maladies of the mind. Prosper them for the better understanding of the guidance and the helpful employment of the mind to the end that there may be ever an increase of those who are able to love Thee with all their minds as well as hearts and souls and strength.

Make us masters of ourselves that we may be the servants of others, giving unto us a right spirit; steadfast, upright, and unconquerable hearts, and humility that we may understand the littleness of our knowledge and the greatness of Thy truth; and may Thine be the kingdom and the power and the glory, world without end, Amen.

THE PRESIDENT.—It is fortunate, fitting and proper that the first address of welcome should be given by the son of the man who called together and welcomed a meeting held 100 years ago, in 1844, in the mansion still standing on the grounds of the Pennsylvania Hospital.

Dr. Kirkbride then welcomed thirteen founding members. His son, Mr. Franklin B. Kirkbride, will

give the first address of welcome to a membership of 3112.

MR. FRANKLIN B. KIRKBRIDE.—Mr. Chairman, it is hard to realize that a century has passed since my father, as one of the Original Thirteen, and first Secretary of the Association of Medical Superintendents of American Institutions for the Insane, extended a cordial welcome to his colleagues, who were assembled here in Philadelphia in a pioneer organized movement to ameliorate the lot of those suffering from mental disorders.

The dining room of my boyhood home on the grounds of the Pennsylvania Hospital for the Insane, which room was also my father's study, the hospital itself and Jones Hotel at 6th and Chestnut Streets formed the background for that historic gathering.

As a youngster I was privileged to know intimately a number of the men who created your Association. The personalities of Isaac Ray and Charles H. Nichols stand out vividly.

It was Isaac Ray who wrote in my autograph album the words "Obsta principiis." Gregory Zilboorg tells me the official meaning of the dictum might mean many things such as "Be careful or cautious about your first impulses" or "Distrust at first anything new" or "Make haste slowly." He inclines to the latter interpretation, "Make Haste Slowly."

Medical jurisprudence, in which Ray was pre-eminent, had made him realize that all true progress is based on tested knowledge. How well the original thirteen and their successors have built on that solid foundation is attested by the achievements of 100 years. Yet the battle is far from won.

One hundred and three years ago my father removed his first patients from the cells in the basement of the old Pennsylvania Hospital at 8th and Pine Streets, did away with restraint in all but the most violent cases and was thought to be out of his mind for doing so.

What a far cry from the popular conception of insanity a century ago compared with the status of psychiatry today!

The basis for much of what has happened since then was the adoption by your Association in its early years, of fourteen propositions and resolutions, ten written by my father, two by Nichols, and one by Ray, which have stood the test of time and paved the way for enlightened progress. These propositions and resolutions cover construction and organization of hospitals for the insane; provision for

all classes of patients; care of chronic and other classes, legal relations; political appointments; restraint; heating and ventilation; religious services; care of insane criminals; overcrowding; didactic and clinical studies; care of inebriates; and finally, reaffirmation of the propositions and resolutions of general principles of management—certainly an all-embracing list.

We meet today, at a time when humanity calls aloud for help which your profession alone can give, when distraught minds are so terribly in need of wise and sympathetic succor in a world torn by strife.

Here, inspired by the vision of Benjamin Franklin and Benjamin Rush, by the achievements of the Original Thirteen and a long line of worthy successors, you meet to advance the banner of psychiatric progress, with the emphasis today on public health as well as the cure of disease.

Private wealth, Foundations, State treasuries, the Federal government all stand ready and eager to back intelligent attacks on the causes of mental disease and defect. The nation cries aloud to you to blaze the way, to map out the program so that "mens sana in corpore sano,"—healthy mind in robust body—may become a national heritage.

In the State of New York alone we spend each year some \$40,000,000—one-third of the operating cost of the State government—in caring for mental disease and defect. How, I ask you, can we best attack this appalling burden?

We look to you for light, Mr. President.

It is a privilege and a joy, as it was my father's good fortune a century ago, to welcome you and your colleagues most heartily on this auspicious anniversary occasion.

THE PRESIDENT.—Might I suggest that in memory of Dr. Kirkbride and as a tribute to his son, the audience rise as an expression of appreciation?

The members present arose and applauded.

THE PRESIDENT.—The Mayor of the City of Philadelphia, the Honorable Bernard Samuel, is prevented by official business from giving an address of welcome. He, however, has sent an able and welcome representative, a distinguished physician, and one who, to the great satisfaction of the medical profession of Philadelphia, has been made Director of Public Health recently.

I give you Dr. Rufus Sargent Reeves, Director of Public Health of the City of Philadelphia.

DR. RUFUS SARGENT REEVES.—Dr. Strecker, distinguished guests, ladies and gentlemen: It is always a privilege to substitute for the Mayor of the City of Philadelphia, whose interest in medical matters is really remarkable when one considers the scope of his activities, but it is a special honor and privilege for me to be here this morning at the opening of this meeting with my distinguished friend, your president.

In behalf of the City of Philadelphia, and acting for Mayor Samuel, I welcome you most cordially. We feel honored in your choosing Philadelphia for

your Centennial Meeting and naturally we are sure you have made a wise choice.

Founded as the home of Brotherly Love, known the world over as the Cradle of Liberty, and particularly to you as the Cradle of The American Psychiatric Association, you have come to the native city of your profession. Your very profession embraces brotherly love and liberty as cardinal principles in its practice and we like to feel that destiny and not mere chance or convenience dictated the birthplace of your association. It certainly was most fitting.

Here, our public care of mental disease began over 200 years ago, in 1732, when a building called the Philadelphia Alms house for the care of the Poor, the Sick, the Infirm, and the Insane was erected only ten blocks east of where you now sit. From this beginning there finally developed the Philadelphia General Hospital, known for over 100 years as Blockley, with its present large Psychopathic Department.

In Colonial days many Blockley mental patients were transferred to the Pennsylvania Hospital which at last, in 1841, organized a separate unit in West Philadelphia which became known as Kirkbride's. With this move there began specialization in psychiatry in this city. The roster of Philadelphians active in behalf of those mentally ill from Benjamin Franklin, who served in Colonial times as Secretary of the Board of the Pennsylvania Hospital, to your distinguished president of today is well known to all of you. The list is too long for recounting and to attempt it would inevitably involve the possible unwitting omission of names deserving the honor of inclusion.

We are told, and are inclined to believe, that our city is the psychiatric center of the country. Today, that means the world. That is a distinction of which we are proud.

Our mental hospitals are many—the Philadelphia State Hospital of 6100 beds, for example, which until 1938 was a branch of the Philadelphia General Hospital, now so ably cared for by your Vice-Chairman, Dr. Zeller. It is one of the largest in the country and its new buildings are well worth a visit.

The Department for Mental Diseases of the Pennsylvania Hospital and its splendid Institute, a combination of the best of the old and the new; the Friends Hospital, the oldest private hospital in this country exclusively for the insane, a pioneer in occupational therapy and psychotherapy; the Neurologic Institute of the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases, on whose staff were S. Weir Mitchell and Charles W. Burr, which is now merged with the University of Pennsylvania; the 300-bed Psychopathic Department of the Philadelphia General Hospital, which admits almost 5,000 cases per year, a splendid observation, treatment, and teaching institution; the Philadelphia Psychiatric Hospital, in whose new buildings most careful examinations and treatments are featured; the Philadelphia Child Guidance Clinic, which has become a model for the whole country.

In addition, a large number of our general hospitals have out-patient clinics devoted to psychiatry.

Our five medical schools—the University of Pennsylvania, Jefferson, Temple, Women's and Hahnemann—maintain courses in neuropsychiatry, whose influence on the young practitioner grows stronger year by year.

Philadelphia's psychiatry has contributed vastly to the Army and Navy personnel during this war. Outstanding is the service given by you, Mr. President, as the guiding star in psychiatric affairs in both branches of the service.

In the 100 years of your association many milestones have been passed. Not the least of them will be this assembly in the city of your birth and under the war conditions of today which make inordinate demands upon your strength and your ingenuity.

We would like to include in the remarks a few words about the city's activities in behalf of those who are admitted to the Philadelphia General Hospital and the Philadelphia Hospital for Contagious Diseases. Nearly \$4,000,000 annually is expended for the maintenance of these institutions. In addition, however, to the operation of the City's hospitals, we have a keen interest in subnormal children committed by the Juvenile Court.

The Philadelphia Department of Public Welfare has now under its care or supervision 3,004 feeble-minded charges, mostly children, all of whom have been committed to the Department by the Juvenile and Misdemeanors Division of the Municipal Court.

Approximately 250 new cases are committed annually to the Department. Therefore, year to year, the number of feeble-minded children for whom the Department is responsible increases. Before commitment by the Court, each subnormal child receives a thorough physical and mental examination by the Medical Division of the Court and recommendations are submitted to the types of placement best suited for the welfare of the child.

In making the commitment, the Court specifies the type of placement which should be made in accordance with the recommendations which have been submitted. The commitment may be to a State institution for training and care or placement in private institutions, such as the Elwyn Training School, or for foster home care.

The City of Philadelphia makes an appropriation of \$175,000 annually for the Bureau of Personal Assistance in the Department of Public Welfare for the purpose of paying the maintenance of the mentally defective children placed in private institutions and for foster-home care.

Of the 3,004 mentally defective children now in care, 1155 are placed in State institutions at no expense to the City of Philadelphia; 924 are maintained by the Department; 88 are at wages in hospitals or at large; and 937 children are in their own homes, awaiting placement in appropriate institutions. The waiting-lists of the State institutions are very long and at the present time no child from Philadelphia can be committed to a

State institution unless an older inmate leaves the institution by removal or death.

We have attempted to discuss this morning some of our City's activities in behalf of the mentally afflicted. I assure you that Mayor Samuel's administration is alive to the seriousness of the problem of mental deficiency and will leave nothing undone to alleviate it.

We trust that your meetings will be most successful and that those who are visitors to Philadelphia will enjoy every minute that they are here. There is much of interest to see in this old American municipality.

In closing, I again extend to you a cordial welcome and trust that when you return to your homes you will carry with you fond recollections of Philadelphia, which we know to be the medical center of the world today.

THE PRESIDENT.—Thank you, Dr. Reeves. Would you please carry to the Mayor our greetings and our appreciation of his hospitality?

The next address of welcome was to be from my good friend Dr. O. H. P. Pepper. Unfortunately, he has been called rather suddenly to Washington on war business but my also good friend, Eugene P. Pendergrass, President of the Philadelphia County Medical Society, is a professor of Radiology; therefore, he is used to functioning in several dimensions, and has agreed to give us welcome from the Philadelphia County Medical Society, and also the College of Physicians of Philadelphia. Dr. Pendergrass.

DR. EUGENE P. PENDERGRASS.—*Mr. President, distinguished guests, ladies and gentlemen:* It is a privilege to bring to you the cordial greetings from the Philadelphia County Medical Society on this, the One Hundredth Anniversary of your Association, and extend to you their best wishes for a most successful meeting.

On behalf of Dr. Pepper it is a great pleasure to extend greetings to you from the College of Physicians of Philadelphia.

The Greeks said, "Know yourself"; the Romans, "Be yourself"; the Christians, "Give yourself." Your great organization has fused these three swords into a great instrumentality and is providing a program for rehabilitation of the mentally ill, of which American Medicine is proud.

We in the Philadelphia County Medical Society, through the agency of our Committee on Nervous Diseases and Mental Hygiene, under the chairmanship of Dr. Samuel Hadden, are conscious of our responsibility to the community concerning its mounting needs to help and guidance in psychiatric care.

It is hoped that increased facilities may be provided for closed collaboration between the general practitioner, the family, and the psychiatrist for all patients requiring psychiatric care. If such an opportunity is provided, your efforts will be greatly enhanced.

I suppose the Government hospitals will provide for the rehabilitation of all who become mentally ill in the service. There are, however, an increas-

ing number of these men and women being discharged to their homes. This will tend to throw a tremendous load of follow-up care on the local doctors whose facilities are already too meagre.

We in Philadelphia and elsewhere look to your association for continued guidance in meeting this tremendous problem of adequate psychiatric care.

In closing, I would like to extend to your president, who is a personal friend, my heartiest congratulations. Philadelphia is proud of his achievements. He is a prophet who is honored at home as well as abroad.

**THE PRESIDENT.**—Thank you, Dr. Pendergrass, for your gracious address of welcome.

The honor of responding to the addresses of welcome is given to the President-Elect of the association, Dr. Karl M. Bowman.

**DR. KARL M. BOWMAN.**—On behalf of The American Psychiatric Association, I wish to express our thanks and appreciation of the kind words of welcome which have been extended to us.

As has been said it is peculiarly fitting that we, who are the oldest medical society in the United States of America, should be celebrating our One Hundredth Annual Meeting here in Philadelphia. It is equally fitting that our president, Dr. Edward A. Strecker, should be a citizen of Philadelphia.

We wish to welcome all of our distinguished visitors, many of whom bring us official greetings from other medical and scientific societies.

In spite of war conditions, it appears now that we shall have the largest attendance in the 100 years of our existence. Everything indicates that this will be the most important and most successful meeting that we have ever held.

We wish to thank our Philadelphia hosts and especially Dr. Frederick H. Allen and his committee for their help in planning all of the arrangements of this meeting.

**THE PRESIDENT.**—Thank you, Dr. Bowman. The Secretary of the Association will now read some messages and letters of greeting from other associations and distinguished colleagues.

**DR. WINFRED OVERHOLSER.**—*Mr. President, ladies and gentlemen:* I have the honor to read you a letter from the Royal Medico-Psychological Association of Great Britain.

"My association was very gratified to receive an invitation to send a representative to attend the Centennial Meeting of The American Psychiatric Association and deeply regrets that owing to the present difficulties of travel it is not possible to appoint a delegate.

"Unfortunately, there is not, as far as I am aware, any member of the Association in America at present to represent us at your celebration.

"The president, council, and members of the Royal Medico-Psychological Association wish me to extend their most cordial congratulations to the president, council, and members of The American Psychiatric Association upon the occasion of their Hundredth Anniversary, and to express their best wishes for your continued prosperity and the hope

that the great work done by your association in the psychiatric field will grow from strength to strength.

"We celebrated our centenary three years ago and are proud to believe that in point of time we take precedence of any other in the world devoted to psychiatry. The association was founded in 1841 and received its Royal Charter in 1926. Although the name of the association has been changed its objectives have always been the same—the betterment of the care and treatment of persons suffering from mental disorders.

"In 1841 the first meeting was attended by six members. Now our membership is well over 1,000. Whilst the majority of these reside in Great Britain and Ireland, we have members throughout the Empire and a few years ago an Indian Division was formed, which is expanding rapidly.

"Dr. Thomas C. Graves, our president, desires me to say that he cherishes memories of his visit to America in 1928, when he had the pleasure of visiting several of your hospitals. He is sorry he is unable to attend your Centennial, but hopes to pay you a visit at some future date.

"We hope that closer cooperation with our sister associations in America will be possible after the war and we look forward to having the pleasure and privilege of welcoming you and any members of your association when you visit this country."

I have also received a cable from Dr. W. Gordon Masfield, Honorary Secretary of the association, who wrote that letter.

The cable reads as follows:

"Heartiest congratulations and greetings on your anniversary from your venerable contemporary, the Royal Medico-Psychological."

I have also a cable from Brigadier John R. Rees, in charge of psychiatric work in the British Army, whom some of you have met in this country.

"All British Army psychiatrists join me in congratulations to association at this time and every good wish for the future."

**THE PRESIDENT.**—The association will now hear the report of the Committee on Arrangements, Dr. Frederick H. Allen.

**DR. FREDERICK H. ALLEN.**—*Dr. Strecker, members and friends of The American Psychiatric Association:* The Committee on Arrangements has been working diligently for months to assure the success of this meeting. The arrangements have had to be made under the difficult conditions of wartime and we hope that you will all be as comfortable as it is possible to be under the conditions that we have had to work with.

We have had the problem of assigning rooms to some 1400 who have signified their interest in coming, a difficult job. Dr. Maeder, who has charge of that, has done well.

I call your attention to the historical exhibit on the 18th Floor, arranged under the supervision of Dr. Bookhammer. This is a noteworthy one and will warrant much of your time in studying its details. It gives the most graphic account of the whole history of psychiatry.

The outstanding event in the social and getting-together line will be on Wednesday evening, at the annual banquet. After it a play will portray events in the development of American psychiatry in a fascinating way.

I ask that all who plan to attend to make arrangements as soon as possible at the registration desk. We are anxious that members and guests shall be accommodated, but the number of tickets is limited.

Preceding the banquet, the Committee on Arrangements is inviting members and guests to a cocktail party to be held in the Clover Room, adjoining the banquet room.

On Tuesday evening, following the round tables, we are having an informal get-together for pleasure and a good time and will at that time show some movies, one old movie that I am sure will be much enjoyed by everyone.

The Women's Committee, under the chairmanship of Mrs. Appel, has arranged an interesting program for women guests. The high spot of their program will be a tea, which will be given tomorrow afternoon from four to six in the Museum of Art on the Parkway. This is a delightful setting and will be a notable tea.

At five o'clock this afternoon there will be a special showing of two official Army pictures in the Rose Garden immediately following one of the section meetings. One film is entitled "Baptism of Fire," and is a very interesting and well acted picture that portrays some important things you will be interested in.

On behalf of the Committee on Arrangements, I am glad to welcome you and I trust we will be able to make your stay comfortable and you will have a profitable meeting with us.

THE PRESIDENT.—The thanks of the Association are due to Dr. Allen and his sub-committeemen who have given so generously of their time and their effort in making such satisfactory arrangements for our meeting at this centenary session.

We will now have the report of the Committee on Program, Dr. Malamud.

Dr. William Malamud (Chairman, Committee on Program) then read his report.

THE PRESIDENT.—Thank you, Dr. Malamud, for your fine work.

At this time I would like to present to the members of the Association and to the guests someone who needs no presentation, a distinguished expert of this organization, the dean of American psychiatry, Adolf Meyer. Will you please stand up, Dr. Meyer?

Dr. Adolf Meyer arose. The members applauded.

THE PRESIDENT.—I now call for the report of the Secretary-Treasurer, Dr. Overholser.

DR. OVERHOLSER.—*Mr. President, ladies and gentlemen:* One hundred years ago this association consisted of 13 members. Today, there are 3,112, divided as follows:

Honorary .....	20
Life members .....	87
Corresponding Members.....	10
Fellows .....	802
Members .....	1,788
Associate Members.....	315

That represents a gain over one year ago of 225. During the year there have been 31 deaths:

Life members.....	9
Fellows .....	13
Members .....	8
Honorary .....	1

As to finances, I am glad to report that the year just closed is most successful. The surplus of the Membership Account was slightly over \$4500 for the year and in the general account approximately \$1100.

There has been a substantial increase in advertising in the JOURNAL and there has been an increase in subscriptions by non-members—all members are *ipso facto* subscribers—an increase of 679. We have a total of over 1600 subscribers to the JOURNAL outside of the membership.

Our total assets at the present time are approximately \$41,000, of which \$15,000 are invested in United States Government bonds and \$3,000 in Canadian bonds.

The report of the certified public accountant is available to any who wish to examine it.

It is a pleasure to acknowledge again the invaluable services of our executive assistant, Mr. Austin M. Davies, and of his assistants, Miss Dorothy Rubenstein and Miss Eve Borduk.

During this past year they have carried an increasingly heavy load of the growing membership, of the large increase in the subscription list, and the considerable extra work involved in the preparations for this meeting. Their services have been extremely valuable to the smooth operation of the services of this association to its members.

Yesterday the Council had a long meeting and will meet again at four-thirty this afternoon in the Green Room. May I ask the members of the council please to note that hour and place?

The report of the Council meeting I shall give you Wednesday morning.

THE PRESIDENT.—Thank you, Dr. Overholser.

This, I think, is perhaps the proper time for the president to express his deep appreciation to the secretary, Dr. Overholser, for his unfailingly able, fine, and helpful work.

This is the time that the Committee on Resolutions is appointed and I appoint the following members: J. Fremont Bateman, Chairman; Walter J. Otis; and Ralph M. Chambers.

The Secretary will now read the memorial for deceased members.

The audience stood while Secretary Overholser read the names of the deceased members as follows:

- Charles K. Reinke, M. D., Colony, Va., died Mar. 12, 1942.  
 William Elliott Dold, M. D., University, Va., died Nov. 9, 1942.  
 Charles B. Mayberry, M. D., Wayne, Pa., died Dec. 27, 1942.  
 Thomas A. Cheavens, M. D., Dallas, Texas, died Feb. 23, 1943.  
 Emory John Brady, M. D., Colorado Springs, Colo., died Apr. 19, 1943.  
 Edward H. French, M. D., Wollaston, Mass., died May 4, 1943.  
 Charles M. Gilmore, M. D., Beacon, N. Y., died May 15, 1943.  
 Freeman A. Tower, M. D., Brattleboro, Vt., died May 22, 1943.  
 Isador H. Coriat, M. D., Boston, Mass., died May 26, 1943.  
 Arthur J. Leader, M. D., Poughkeepsie, N. Y., died May 31, 1943.  
 Francis E. Devlin, M. D., Montreal, Canada, died June 29, 1943.  
 Julian N. Wolfsohn, M. D., San Francisco, Calif., died July 1, 1943.  
 Clifford W. Beers, New York, N. Y., died July 9, 1943.  
 Meyer K. Amdur, M. D., Cincinnati, Ohio, died July 15, 1943.  
 Charles Ricksher, M. D., Morganton, N. C., died July 18, 1943.  
 Samuel B. Pond, M. D., Patton, Calif., died July 20, 1943.  
 Allen Ross Diefendorf, M. D., New Haven, Conn., died July 30, 1943.  
 C. Roland Bennett, M. D., Fresno, Calif., died Aug. 11, 1943.  
 C. Macfie Campbell, M. D., Boston, Mass., died Aug. 14, 1943.  
 Eugene C. Ciccarelli, M. D., New York, N. Y., died Sept. 24, 1943.  
 Ira S. Wile, M. D., New York, N. Y., died Oct. 9, 1943.  
 E. L. Horger, M. D., Columbia, S. C., died Oct. 22, 1943.  
 Edward H. Clark, M. D., Des Moines, Ia., died Nov. 6, 1943.  
 Roy Dennis Halloran, M. D., Washington, D. C., died Nov. 10, 1943.  
 Ambrose F. Dowd, M. D., Newark, N. J., died Nov. 16, 1943.  
 L. P. Longino, M. D., Milledgeville, Ga., died Nov. 20, 1943.  
 S. S. Hill, M. D., Wernersville, Pa., died Nov. 22, 1943.  
 Charles S. Trites, M. D., Napanoch, N. Y., died Dec. 7, 1943.  
 James W. Milligan, M. D., Madison, Ind., died Jan. 5, 1944.  
 Phillip Smith, M. D., New York, N. Y. died Jan. 9, 1944.

Giles W. Thomas, M. D., New York, N. Y., died Jan. 12, 1944.

Bernard Sachs, M. D., New York, N. Y., died Feb. 8, 1944.

Charles W. Burr, M. D., Philadelphia, Pa., died Feb. 19, 1944

THE PRESIDENT.—A memorial to a distinguished psychiatrist, a former president of this Association, Dr. Charles Macfie Campbell, will be read by Dr. Harry C. Solomon, of Boston.

#### DR. CHARLES MACFIE CAMPBELL

DR. HARRY C. SOLOMON.—Many of us recall with pleasure the charm of the toastmaster of last year's banquet of The American Psychiatric Association. The geniality, the gaiety, the wit, the sparkling eye, the quick and gracious repartee, the well-chosen words evident at that occasion were characteristic of one facet of the personality of the former president of this Association—Dr. Charles Macfie Campbell. It is certain that none who saw Dr. Campbell on that evening or during the meeting suspected that he had but two months more of life; yet he himself knew that his days were few. This is indicative of other personality traits—self-reliance, self-discipline, the ability to face life and death with equanimity, to live life fully. He had a native endowment of high intelligence which was developed by a fine classic and humanistic education and qualified by much human sympathy.

He was destined for leadership and as he chose psychiatry for his field of endeavor he naturally became a leader in the American and international areas as attested by the presidency of the American Psychiatric Association, the American Board of Psychiatry and Neurology, the Massachusetts Psychiatric Society, the Boston Society of Psychiatry and Neurology, the Massachusetts Society for Mental Hygiene. He was a member of the Royal College of Physicians of Edinburgh, a Fellow of the American Academy of Arts and Sciences, a Corresponding member of the Royal Medico-Psychological Association, the Royal Society of Medicine, Section of Psychiatry, the Societ  de Neurologie de Paris, Professor of Psychiatry of the Harvard Medical School, and Medical Director of the Boston Psychopathic Hospital.

He held the following lectureships: The Shattuck Lecture, Pasteur Lecture, Gehrmann Lectures, Lowell Lectures, and the Salmon Lectures.

This will serve as a partial list of the recognitions which he received.

Probably his most important contribution, however, consisted of his teaching young men and women specializing in psychiatry. To numerous students, internes, assistant physicians, and fellows passing through his hands year after year he gave a fundamental training and imparted his wisdom. His point of view concerning psychiatry thus inculcated in the minds of many people scattered over this country and abroad has deeply influenced the current of psychiatric thought.

A few extracts from his published work will give the flavor of his viewpoint.

"The prestige attached to research dealing with the impersonal processes of disease leads some to hold that further progress in psychiatric investigation must await advances in the basal sciences. It is dangerous, however, for psychiatry to take this dependent attitude towards the solution of its special problems and to demand too much from other disciplines. Psychiatry has its own special problems which have to be dealt with by appropriate methods. The behavior and inner experience of the individual can not be adequately studied by any method of analysis which does not take into account the nature of man. Human nature can not be adequately analyzed by the methods of chemistry and physiology and general biology."

"The fact that an organism was competent to deal with its simpler chemical and organismal problems was no guarantee that it was competent to deal with the demands of the social environment, and the latter ability could only be estimated by studying in detail the life experience of the individual, his reaction to the specific conditions of his life, to prolonged situations, and to episodic strains. It might not be possible to measure the resistance of the individual and his adaptability in the same precise terms as one could measure the organismal immunity of the individual, his reaction to muscular exercise or to the ingestion of sugar, but this lack of precision had to be accepted as determined by the very nature of the problem."

"The study of the psychosis as a problem in human adaptation was the study of the individual personality with its own life history and life situation, and the personality came to occupy the center of the psychiatric stage."

"The approach to the individual case is catholic, and the effort is made to apportion their respective values to somatic, personal, and environmental factors, and to step in therapeutically wherever there is a chance of being of help."

"The essential principles of the disorder in those cases which end in bankruptcy may be the same as in other cases in which, however, there are enough assets, internal or external, to make recovery possible."

"The idea that every patient is an individual problem and not merely a particular example of a recognized disorder is to some disturbing. Order is heaven's first law and the craving for order and system has dominated the formulations of many psychiatrists. Life, however, is not a very orderly process; unexpected, irregular, and unusual situations develop. Human nature is a very imperfect system; the individual is not a standardized article. No rigid system of classification can do justice to the great variety of life experiences."

"With a schizophrenic patient the psychiatrist is dealing with more than a disease, he is dealing with a fragment of an individual destiny."

The American Psychiatric Association indeed has been deprived of one of its leading members, but his spirit will remain with us.

THE PRESIDENT.—A memorial to Colonel Roy Dennis Halloran, Medical Corps, United States Army, a distinguished Fellow of this association, who was the first psychiatrist to serve in charge of psychiatry in the office of the Surgeon General of the Army in World War II, and who gave his life for his country, will be read by Lieutenant Colonel Malcolm J. Farrell, Medical Corps, United States Army.

#### COLONEL ROY DENNIS HALLORAN

LIEUTENANT COLONEL MALCOLM J. FARRELL.—On November 10, 1943, military and civilian neuropsychiatrists were shocked to learn that Colonel Roy D. Halloran had died at Washington, D. C., after a very brief illness.

Colonel Halloran was an outstanding psychiatrist and an able administrator, a quiet and dignified man of mature judgment.

Born in Cambridge, Massachusetts, August 4, 1894, he received his academic education at Dartmouth and his professional education at Columbia. After an internship at the old City Hospital in Newark, N. J., he joined the staff of the Boston State Hospital in 1922. His administrative and organizing ability, as well as his professional abilities, were recognized early. In the short space of six years he rose from the ranks to become assistant superintendent of the Boston State Hospital. In 1929 he became assistant to the Commissioner of the Massachusetts Department of Mental Health.

He supervised the organization of the new Metropolitan State Hospital in Waltham, Massachusetts, becoming its first superintendent in 1933. The Metropolitan State Hospital stands as a tribute to him, a crowning achievement of his organizing ability.

He was granted a military leave of absence when called to head the newly organized branch of Psychiatry in the office of the Surgeon General.

Colonel Halloran contributed much to medical and psychiatric research and education. In 1929 he was appointed assistant professor of clinical psychiatry at Tufts Medical School and was made professor in 1939.

He was the co-founder and director of the American Post-Graduate Seminars in Psychiatry and Neurology, which were organized at the Metropolitan State Hospital in 1936. The success of these seminars, attested by the development of similar courses in other sections of the country, was evident.

He was a Fellow of this association and other important medical organizations.

On August 17, 1942 he was called to the service of his country with the rank of Colonel. In his all too brief career as chief consultant in Neuropsychiatry he carried over his civilian abilities and interests. Although he carried his responsibilities well those who were close to him realized the effect of the heavy cares placed upon him even to the death.

The American Psychiatric Association has lost an outstanding member. He was a leader who will long be remembered.

His family has lost a devoted husband and father and to them we extend our sympathy.

He died in his country's service and his burial in Arlington Cemetery with full military honors was a fitting climax to a brilliant career.

THE PRESIDENT.—This concludes the first, the opening session of the association.

Whereupon the first business meeting was closed at 10.45 a. m.

## TUESDAY MORNING SESSION

MAY 16, 1944

The meeting was called to order by the President, Dr. Edward A. Strecker, at 9.15 a. m.

PRESIDENT STRECKER.—The first item is the report of the Nominating Committee to be given by Dr. Chapman.

DR. R. M. CHAPMAN.—Mr. President, your Nominating Committee presents for President, Karl M. Bowman; for President-elect, Samuel W. Hamilton; for Secretary-Treasurer, Winfred Overholser; for Councillors, Edward A. Strecker, R. Finley Gayle, John P. S. Cathcart, and Frederick P. Moersch; for Auditor, Garland H. Pace.

ABRAM E. BENNETT,  
EARL D. BOND,  
R. M. CHAPMAN,  
ARTHUR H. RUGGLES,  
HENRY W. WOLTMAN.

PRESIDENT STRECKER.—You have heard the report of the Nominating Committee. Are there any other nominations? If not, what is your pleasure?

MEMBER.—Mr. President, I move the nominations be closed and the slate proposed by the committee elected unanimously.

PRESIDENT STRECKER.—You have heard the motion that these officers be unanimously elected. Do I hear a second to the motion?

Motion seconded and passed.

PRESIDENT STRECKER.—I declare these officers elected, and the association extends its sincere congratulations to the new President-to-be and the President-elect.

There is now a question of amending the constitution. The Secretary will explain it to you.

SECRETARY OVERHOLSER.—*Mr. President, ladies and gentlemen:* The constitutional requirements concerning an amendment to the constitution have been complied with. Publication has been made. Announcement was made at the meeting a year ago that this amendment would be proposed, namely, that in section 3 of article 3 of the constitution, the words "board of examiners" shall be substituted by the words "Committee on Membership" and the

rest of the language of the section changed accordingly. The change is entirely one of title, not of function.

I move the adoption of this amendment, Mr. President.

Motion seconded and passed.

PRESIDENT STRECKER.—The constitution is amended in the manner described by the secretary.

We now have a brief report of the special war committee to be given by its chairman, Arthur Ruggles.

Reading of report by Dr. Arthur Ruggles. (See p. 253.)

PRESIDENT STRECKER.—It now becomes my official duty and personal pleasure to yield the chair to my good friend, Colonel William C. Menninger, for the first military program of the meeting, the Army program.

Without any intention of deferring relinquishment of the chair, I cannot resist saying a few words about the splendid work accomplished by Colonel Menninger. He assumed his duties on the 10th of December, and in this short period of time has made notable strides, not only in progress and more satisfactory situation concerning neuro-psychiatry in the Army, but psychiatry has been made in the office of the Surgeon General a division on a level with medicine and surgery. Furthermore, divisional psychiatrists who are really the backbone of psychiatry in the Army have been assigned and are functioning. If I told you of all the progress that has been made I would be making an unfair encroachment upon the time of this most important program.

I therefore yield the chair to Colonel Menninger.

COLONEL WILLIAM C. MENNINGER.—In our midst we have quite a number of our associates from Canada. We would like to have General Brock Chisholm, Director General of Medical Service in the Canadian Army, come up and share the platform with us. And Colonel John Griffin, Chief of Psychiatry for the Canadian Army, also join us on the platform. We are looking for Colonel John Murray, in charge of psychiatry in the office of the Air Surgeon.

Dr. Strecker made some gracious remarks but it would be entirely misleading if I didn't make it clear that what little has happened has been largely because we have seven of the best psychiatrists we have in the country working in the Army as Service command consultants, and because in our office in Washington I have had the enthusiastic and devoted help of six other men, every one of whom is carrying the ball.

It is with special pleasure that I introduce to you first my right hand and my left hand, Colonel Mal Farrell, who will present a paper on the Current Trends in Military Neuro-Psychiatry.

Adjournment.

## WEDNESDAY MORNING SESSION

MAY 17, 1944

The meeting was called to order by the President, Dr. Edward A. Strecker, at 9.45 a. m.

**PRESIDENT STRECKER.**—Will the representatives of the original hospitals take seats on the platform, please?

Meantime, you will be interested in hearing that the registered attendance, I understand, breaks all records of the association. With still a number of uncounted cards, there were last night 1924 registrations: 982 members and 942 non-members.

Dr. Allen, in charge of the Committee on Arrangements, will make a few announcements before we begin the program.

**DR. ALLEN.**—It is important that those who wish to purchase a copy of the memorable and important centenary volume get your order in at once because there is a limited number of books that are available. If you do not get your volume at the present time, there is a very real question whether you will be able to buy one.

The Navy League, who have been helping us so much in the preparation and carrying out of this convention, can provide transportation for parties of five to any of the various hospitals and clinics in the vicinity of Philadelphia, if you will make those arrangements on the ground floor at the desk that is marked for that purpose.

**PRESIDENT STRECKER.**—We will now have the report of the Council, which will be given by the secretary, Dr. Overholser.

**SECRETARY OVERHOLSER.**—*Mr. President and ladies and gentlemen:* Two meetings of the Council have been held during this session: Sunday afternoon and evening, and Monday afternoon. I shall give a summary of the important actions. A full account of the Council meetings will be published in a later edition of the JOURNAL.

The Council approved the report of the Executive Committee and the recommendations of the Executive Committee as follows: That there be a meeting of the Council of not less than three days to be held in December, 1944, for a full consideration of the future plans of the association. That the New Orleans Society of Neurology and Psychiatry be recognized as an affiliate society of the Association. That the study of plans for a permanent home of The American Psychiatric Association in New York City be further considered and expedited as rapidly as possible. That Chicago be designated as the convention city for 1945. That the sale of advertising space in the front pages of the JOURNAL be approved. That the incoming President, Dr. Bowman, be added to the Special Committee on Psychiatry in the Armed Forces, and that the present members be continued in office.

Various committees of the Association reported to the Council through their chairmen. The reports

will be printed in full in the JOURNAL for the information of the Association. They were accepted and appropriate action was authorized by the Council. The editorial board of the centenary volume reported through Dr. Zilboorg and the board was discharged with a special vote of appreciation of their work in producing a volume of which the Association is justly proud.

The salaries of the staff of the association were increased as follows: Mr. Austin Davies increased to \$5,700; Miss Rubinstein to \$2,450; Miss Borduk to \$2,400; and Mrs. Laura Fitzsimmons, the nursing consultant under the Rockefeller grant, increased to \$4,800. All these rates per annum.

Dr. Myerson reported that the Committee on Research had awarded the Devereaux prize of \$500 to Dr. William Goldfarb of New York City. It was voted to request Dr. Ruggles to present the report of the Special Committee on Psychiatry in the Armed Forces before the general session of the Association. This he did Tuesday morning. It was voted to authorize the recording of certain of the proceedings to be deposited with the Surgeon General's library. The report of the Board of Examiners concerning elections and transfers was approved and will be presented to the association for its action tomorrow morning.

It was voted to nominate Dr. Harold D. Palmer, of Philadelphia, to the American Board of Psychiatry and Neurology to serve as a member on behalf of the association, succeeding Dr. E. A. Strecker.

A very cordial communication from the American Psychoanalytic Association and the section on psychoanalysis, expressing their congratulations to the Association on its one hundredth anniversary, and expressing pride in being official partners and co-workers of the association, was received. The Secretary was directed to make suitable acknowledgment.

Dr. Farrar reported the appointment of Dr. S. Spafford Ackerly to the editorial board of the JOURNAL. The report of the editor was accepted with congratulations on the centenary issue.

I move you, Mr. President, the acceptance of this report by the Association, and the ratification of the acts of the Council and Executive Committee since the last annual meeting.

**PRESIDENT STRECKER.**—You have heard the report of the Council and the motion for its acceptance and ratification.

Motion seconded and passed.

**PRESIDENT STRECKER.**—It is so moved and carried. The Secretary had an announcement.

**SECRETARY OVERHOLSER.**—I wish to announce the reports of the elections in the various sections for the coming year.

Section on Forensic Psychiatry; Chairman, Dr. Sara Geiger, of Milwaukee; vice-chairman, Dr. Harvard Kaufman, of Pittsburgh; secretary, Dr. O. Spurgeon English, of Philadelphia.

Section on Psychoanalysis: Chairman, Dr. O.

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Spurgeon English, of Philadelphia; vice-chairman, Dr. Robert P. Knight, of Topeka, Kans.; secretary, Dr. Gregory Zilboorg, New York City.

Section on Convulsive Disorders: Chairman, Dr. David E. McBroom, of Cambridge, Minn.; secretary, Dr. Willard H. Veeder, of Sonyea, New York.

Section on the Psychopathology of Childhood: Chairman, Dr. George S. Stevenson, of New York City; vice-chairman, Dr. Edward J. Humphreys, Coldwater, Mich.; secretary, Dr. Oscar J. Raeder, of Boston.

May I announce for the benefit of the newly elected councillors, as well as those whose term runs after this session, that there will be a meeting of the Council in the Green Room tomorrow afternoon, Thursday, at 4.30. It will be a brief session.

PRESIDENT STRECKER.—I think you will be interested in learning that for the first time in the history of the Association, the proceedings of this centenary meeting today and other parts of the program are being recorded for posterity through the courtesy of Captain Albert A. Rosner so that we can visualize one hundred years from now, at the second centenary meeting, that the things we say will be subjected to the critique of the collective super ego of those who are members one hundred years from this day.

Next we will have the report of the auditors, which will be given by Dr. Castner.

DR. CASTNER.—The auditors' report, which has been prepared by Mr. A. A. Turoff, of New York City, has been approved by all three members of the board: Dr. Ralph Hammill, and Dr. Carlisle and myself.

I move that the report be adopted.

PRESIDENT STRECKER.—It has been moved that the report of the auditors be adopted.

Motion seconded and passed.

PRESIDENT STRECKER.—We will next have the presentation of the fellowship certificates, and I would say briefly that the fellows who will this year receive their fellowship certificates have an unusual privilege and pleasure. They will receive them from the hands of Benjamin Rush, a direct lineal descendant of our great Benjamin Rush, who was such a significant figure not only in the history of American psychiatry but in the history of our democratic independence. I should like to introduce to you Mr. Benjamin Rush, Jr.

The Secretary will call the list of fellows. Those present will come forward and receive their certificates from the hands of Mr. Rush.

SECRETARY OVERHOLSER.—Dr. David A. Boyd, Jr.; Captain Morris W. Brody; Commander James H. Closson; Dr. Alexander G. Dumas; Dr. Dean H. Duncan; Captain John R. Ernst; Major Harry L. Freedman; Dr. Frieda Fromm-Reichmann; Dr. Stewart T. Ginsberg; Lt. Col. Roy R. Grinker; Dr. Frank W. Haas; Dr. Coyt Ham; Dr. Edna P. Henry; Dr. Paul H. Hoch; Dr. Martin H. Hoffmann; Dr. William A. Horwitz; Dr. Sylvan Keiser;

Dr. Luisa Kerschbaumer; Dr. Isham Kimbell; Dr. Josef A. Kindwall; Dr. Jefferson F. Klepfer; Lt. Commander Zigmond M. Lebensohn; Dr. William G. Lennox; Dr. Basilia Lipetz; Dr. Gomer S. Llewellyn; Dr. Harold W. Lovell; Dr. Charles F. Menninger; Dr. Warren G. Murray; Dr. John F. Owen; Major Frank P. Pignataro; Captain Norman Reider; Lt. Col. Seymour J. Rosenberg; Dr. Conrad S. Sommer; Major Louis Steinberg; Dr. James Watson; Dr. Stephen Weisz; Dr. Norman Westlund; Dr. Helen L. Williams-Hodgens; Dr. George W. Wilson.

PRESIDENT STRECKER.—To the new fellows of the association from Mr. Benjamin Rush and from every member of the association, our sincere admiration and congratulations upon this objective and honor which they have achieved. Our good wishes go with them.

One cannot resist some analogy between the representatives of the original thirteen hospitals and those great patriots who gave their signatures to our Declaration of Independence from the thirteen original states. The analogy would seem to be obvious. The patriotic signers gave their names to an immortal document which stands out in defense of the liberty of men. These signers and founders also struck a blow in defense of the freedom of psychiatry, defiance of whatever the vested interests of psychiatry in that day were, a declaration of the dignity of man even though he may be ill in his mind, and a freedom for the discipline of psychiatry which has since flourished and flowered to its present fine condition.

Of the thirteen original hospitals whose superintendents constituted the first American Psychiatric Association, there are two hospitals which are no longer in existence. The founders from those two hospitals were Dr. Samuel White and Dr. Nehemiah Cutter. They were at that time experimenting with private sanatoria, and those original hospitals are no longer in existence.

The other eleven men were associated with eleven hospitals which have continued their growth during the last century and have made an enormous contribution to the evolution and progress of this Association and in the right direction for the care of the mentally sick. We are privileged to have with us this morning the representatives of those original eleven hospitals.

From the first hospital, the Eastern State Hospital, of Williamsburg, Va., the founding member being Dr. John Minson Galt, we have the double privilege of having with us his grandnephew, Major William Richard Galt, who will stand as a symbol of that original Eastern State Hospital of Williamsburg, Va.

From another Virginia hospital, the Western State Hospital of Staunton, from which hospital the original founder was Dr. Francis T. Stribling, represented in person today by Dr. Hugh Carter Henry.

The Pennsylvania Hospital of Philadelphia, the original founder and the first secretary of the Association was Dr. Thomas Story Kirkbride, and we have a great deal of satisfaction in having that

great psychiatrist and humanitarian represented by his daughters, the Misses Kirkbride.

The New York Hospital, White Plains, N. Y., one hundred years ago the founder being Dr. Pliny Earle, represented in person by a distinguished psychiatrist and past president of this Association, Dr. Charence O. Cheney.

The McLean Hospital of Waverley, Mass., who one hundred years ago contributed as a founder Dr. Luther V. Bell, represented today by Dr. Kenneth J. Tillotson, who has been such an active and helpful member of this Association.

The Hartford Retreat, of Hartford, Conn. The original founder from the Hartford Retreat was Dr. John S. Butler. He is represented today in the person of Dr. C. Charles Burlingame, the present superintendent and director of Hartford Retreat.

The Utica State Hospital, Utica, N. Y., the original founder was Dr. Amariah Brigham, and we have a double privilege in having him represented by two members of this Association, the one being an ex-president and a much beloved member, Dr. R. H. Hutchings and Dr. Willis E. Merriman.

The Ohio State Hospital, of Columbus, Ohio. The original founder from this hospital was Dr. William M. Aul, and he is represented by a prominent member of this Association, the chairman of the Committee on Resolutions, Dr. J. E. Bate-man.

The Worcester State Hospital, of Worcester, Mass., which sent to the original founding of the Association Dr. Samuel B. Woodward, is represented today by Dr. Bardwell H. Flower.

The Augusta State Hospital, of Augusta, Me., sending one hundred years ago a founder whose name is as potent in stirring the best interests of psychiatry and psychiatric activities today as it was one hundred years ago, the great Dr. Isaac Ray, is represented today by Dr. Forrest C. Tyson.

The Boston State Hospital, Boston, Mass., who sent to the first meeting of this Association Dr. Charles E. Steadman. The Boston State Hospital is split in two, and the two representatives who stand today for the original Boston State Hospital are both prominent and active members of the association: Dr. Harry C. Solomon and Dr. Abraham Myerson. If they are in the audience will they please stand?

And so it is recorded in the archives of this association that on this, our centenary day, we were able to present to the Association the representatives of eleven of the thirteen original founding hospitals and members. I suggest to you that it is not too much to say that we are at a historical moment. Could we stand for a moment in deference to this momentous occasion?

Audience stands in silence.

PRESIDENT STRECKER.—Thank you.

I will now ask Dr. Ruggles, as immediate Past President, to read a letter of greeting from the President of the United States.

DOCTOR RUGGLES.—

"THE WHITE HOUSE, WASHINGTON

March 14, 1944.

"DEAR DOCTOR STRECKER:

"Will you be good enough to extend for me my sincere greetings to the members of The American Psychiatric Association at its century meeting in Philadelphia?

"The members of your Association are giving to the nation a most needed service in this time of war. The number of men who are being returned to this country from combat areas, with neuropsychiatric conditions, calls for the most efficient handling that is humanly possible. These men must be rehabilitated and enabled to return to civil life as useful members of their communities. Without the assistance of the members of your Association, this cannot be brought about as there is a great lack of competent psychiatrists in our country and many are needed to care for the tremendous number of men who are entering our hospitals in such a short space of time.

"I am told that practically every member of The American Psychiatric Association, unless barred by age or disability, is in the Army, the Navy, the Merchant Marine, or the Veterans Administration. This is a splendid record of service. You, yourself, are giving much of your time to the Navy as an Honorary Consultant, serving on various boards and commissions, aiding the government in psychiatric matters.

"Let me wish for you in this hundredth year of the American Psychiatric Association that much good will come of your deliberations and that you will continue to give the high form of service to your country that you have in the past.

"Very sincerely yours,

"/s/ FRANKLIN D. ROOSEVELT.

"DR. EDWARD A. STRECKER,

President,

American Psychiatric Association,  
Philadelphia 39, Pa."

PRESIDENT STRECKER.—I have now added to my privileges as president the introduction of three centenary speakers. The first speaker has many distinctions. The one that I like to think of, which means a good deal to me personally, is that he is a psychiatrist and at the same time is Director General of the Medical Services, Department of National Defense Army, Canada. We have here a psychiatrist who is the director of the medical service of an army. I almost feel like saying to others, "Go thou and do likewise." I introduce to you Major General George B. Chisholm, who by invitation will address you on The Psychological Adjustment of Soldiers to the Army and to Civilian Life.

After addresses by Professor T. North Whitehead and Dr. Alan Gregg the meeting adjourned.

## THURSDAY MORNING SESSION

MAY 18, 1944

The meeting was called to order by President Edward A. Strecker at 9.10 a. m.

PRESIDENT STRECKER.—May we have the report of the Committee on Resolutions?

DR. J. F. BATEMAN.—Mr. President, in accordance with established custom, the Committee on Resolutions reports:

*Be it resolved*, That this, the centenary meeting of The American Psychiatric Association now being held in Philadelphia, the City of Brotherly Love, the place of its birth, marking one hundred years of continued psychiatric progress despite the turmoil and strife throughout the world, that its membership pledge itself individually and collectively to the continuance of the policies so ably formulated by the original thirteen in this city one hundred years ago. Most especially does the Association reaffirm the urgent necessity of freedom from political interference in the management of public mental hospitals, and likewise the principle that the direction of such hospitals should be vested in psychiatrically trained physicians.

*Be it resolved*, That the Association is mindful of the excellence of the service being rendered now by the members in the armed forces; that it is fully aware of the progress that has been made in the treatment of casualties arising in and out of the war; that an expression of appreciation be communicated to the Surgeon General of the Army and the Surgeon General of the Navy, and the Public Health Service and the Director General of the Canadian Army and Air Force, for their courtesy in making it possible for so many members of this service to attend and participate despite the exigencies of the present-day situation.

*Be it resolved*, That the Association is deeply indebted to its President, Edward A. Strecker, for his successful administration of this epoch-making centenary meeting and for his contributions both to the Association and to psychiatry in general, and in particular his recent work with the armed forces.

*Be it resolved*, That the Association express its appreciation to Dr. Karl M. Bowman, the President-elect; Dr. Winfred Overholser, the Secretary-Treasurer; the members of the Council; the chairmen and members of the various standing committees, for their untiring efforts and helpful collaboration.

*Be it resolved*, That the Association express its appreciation to Dr. Frederick H. Allen, chairman; Drs. Jefferson D. Ellwood, Charles A. Zeller, vice-chairmen; Mrs. Madeline Appel, the Women's Arrangements Committee, and to all other members of the Committee on Arrangements for their efforts in making this meeting an outstanding success.

*Be it resolved*, That the Association is extremely grateful to Dr. Earl D. Bond and the members of the Centenary Committee for their valuable contribution in making the meeting a fitting observance of the centennial of the Association.

*Be it resolved*, That the Association is particularly indebted and most grateful to Dr. J. K. Hall, general editor; his associate, Dr. H. A. Bunker, and especially Dr. Gregory Zilboorg and to the other members of the editorial board of the centenary volume for having made such a valuable contribution to medical history.

*Be it resolved*, That Dr. Robert S. Bookhammer and the members of his special sub-committee be tendered the highest commendation of the Association for the excellent and unusual historical exhibit depicting American psychiatry during the past one hundred years.

*Be it resolved*, That Dr. William Malamud and the other members of the Program Committee be commended for their excellent arrangement of the scientific program.

*Be it resolved*, That we gratefully acknowledge the indebtedness of the Association to the Rev. Frederick R. Griffin, Pastor, First Unitarian Church, Philadelphia; Dr. Rufus Reeves, Director of Public Health, Philadelphia; Dr. Eugene Pendergrass, President, Philadelphia County Medical Society, and especially to Mr. Franklin B. Kirkbride, son of the first secretary of the Association and its second president, for their kind participation in the official opening of the centenary meeting.

*Be it resolved*, That the Association is always mindful of the untiring effort and splendid service rendered by Mr. Austin M. Davies and his assistants.

*Be it resolved*, That the thanks of the Association be extended to the members of the press for their assistance in reporting the proceedings of the Association, and to the management of the Bellevue Stratford Hotel for the excellent manner in which they have handled the largest meeting of the Association.

Respectfully submitted,  
J. F. BATEMAN,  
RALPH M. CHAMBERS,  
WALTER J. OTIS.

PRESIDENT STRECKER.—Dr. Bateman, one of the important things about any meeting is giving thanks where thanks are due, and you have expressed them most adequately and gracefully, and your resolutions will be preserved in the archives of the Association.

Will someone move that these resolutions be adopted?

Motion made, seconded and passed.

PRESIDENT STRECKER.—The resolutions are adopted.

The next item on the program for which we are now preparing is the election of members. The Secretary will make an announcement concerning the election of members.

SECRETARY OVERHOLSER.—*Ladies and gentlemen*, I am sorry to say that there has been some delay in the mimeographing and the sheets have just arrived. We have had no time to put them together and distribute them. They are all on this table at

the front. I'm sure that you would all like to see what is proposed before you act upon them. If those of you who are interested will come forward, there are about half a dozen different sheets in different piles.

The list follows:

#### HONORARY MEMBERSHIP

Maclay, Honorable Walter S., Mill Hill Emergency Hospital, London, England.  
McIntire, Ross T., Vice-Admiral, Surgeon General of the U. S. Navy, Washington, D. C.

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#### CORRESPONDING MEMBERS

Bosch, Gonzalo, Buenos Aires, Argentina.  
Endara, Julio, Faculty of Medicine, Venezuela 47, Quito, Ecuador.  
Lewis, Aubrey Julian, Mill Hill Emergency Hospital, London, England.

(3)

#### TRANSFER FROM MEMBER TO FELLOW

Alcorn, Douglas E., Maj., Esquimalt Military Hospital, Victoria, B. C., Can.  
Anderson, Camilla M., 4803 17th St., N. W., Washington, D. C.  
Anderson, Robert C., Lt. Col., School of Aviation Medicine, Randolph Field, Texas.  
Baer, Walter H., Capt. M.C., Station Hospital, Camp Ellis, Ill.  
Beck, Richmond J., Lt. Comdr., U. S. Naval Training Station, San Diego, Calif.  
Biddle, William E., Warren State Hospital, Warren, Pa.  
Britt, Robert E., 634 N. Grand Ave., St. Louis, Mo.  
Burkes, DeWitt C., 1020 S. W. Taylor St., Portland, Ore.  
Cook, George H., Ionia State Hospital, Ionia, Mich.  
Darrah, Lee W., Northampton State Hospital, Northampton, Mass.  
Duval, Addison M., St. Elizabeths Hospital, Washington, D. C.  
Eisner, Eugen A., Lt. M.C. V(S) U. S. Naval Dispensary, Navy Dept. Washington, D. C.  
Epstein, Samuel H., U. S. Marine Hospital, Baltimore, Md.  
Ewalt, Jack R., 816 Strand St., Galveston, Texas  
Fellows, Ralph M., 9035 Watertown Plank Road, Wauwatosa, Wisc.  
Ford, Hamilton F., Capt. M.C., Fort Worth Army Air Field, Ft. Worth, Texas  
Friedman, Emerick, Capt. M.C., Office of the Surgeon Station Dispensary, 53rd Field Training Unit, A. A. F. P. S. Carlstrom Field, Fla.  
Fuerst, Rudolf A., 43 East Ohio Street, Chicago, Ill.  
Goldman, George S., Maj. M.C., Consultation Service Hdqs. T. R. T. C. Camp Wheeler, Ga.  
Graves, Jr., Charles C., New Jersey State Hospital, Marlboro, N. J.

Huber, Charles B., Veterans Administration Facility, Pittsburgh, Pa.  
Kelling, Jordan A., Capt. M.C., Station Hospital, Camp Shelby, Miss.  
Lemkau, Paul V., Capt. M.C., School of Hygiene and Public Health, 615 N. Wolfe St., Baltimore, Md.

Lewy, Ernst, 3617 W. Sixth St., Topeka, Kans.  
Liber, Benzion, 65 W. 95th St., New York 25, N. Y.  
Madden, John J., 6 No. Michigan Avenue, Chicago, Ill.

Maletz, Leo, Danvers State Hospital, Hathorne, Mass.

Orenstein, Leo L., Capt. M.C., Station Hospital, Ft. Benning, Ga.

Pearson, Grosvenor P., Western State Psychiatric Hospital, Pittsburgh, Pa.

Rosner, Albert A., Maj. M.C., Station Hospital, Greensboro, N. C.

Ross, Nathaniel, 9 East 96th Street, New York 28, N. Y.

Rowe, Melvin J., Mendocino State Hospital, Talma, Calif.

Schwade, Edward D., Lt. Col. M.C., Station Hospital, Camp Fannin, Tex.

Simon, Benjamin, Maj. M.C., Mason General Hospital, Brentwood, N. Y.

Steward, Genevieve M., Medical Arts Bldg., 16th & Walnut Sts., Phila., Pa.

Turow, Irving L., Maj. M.C., Station Hospital, Ft. Custer, Mich.

Twyeffort, Louis H., 111 N. 49th St., Philadelphia, Pa.

Weigert, Edith V., 12 Oxford St., Chevy Chase, Md.

White, Paul L., Capt. M.C., Station Hospital, Camp Chaffee, Ark.

Williams, James N., 501 E. Franklin St., Richmond, Va.

Yerbury, Edgar C., 100 Nashua Street, Boston, Mass.

Zeifert, Mark, Lt. Col., Hammond General Hospital, Modesto, Calif.

Ziskind, Eugene, 2007 Wilshire Blvd., Los Angeles, Calif.

Zabriskie, Edwin G., 115 E. 61st Street, New York City, N. Y.

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#### REINSTATEMENTS AS MEMBER

Doggett, Sylvester, Anna State Hospital, Anna, Ill.

(1)

#### TRANSFER FROM ASSOCIATE MEMBER TO MEMBER

Altman, Louis D., First National Bank Bldg., Greensburg, Pa.

Berns, Robert S., 415 N. Camden Drive, Beverly Hills, Calif.

Bradshaw, Jr., Frederick J., Maj., Barnes General Hospital, Vancouver, Wash.

Burkett, Howard M., Capt. M.C. Hdqs. 70th Infantry Div., Camp Adair, Ore.

Cameron, Dale C., U. S. Coast Guard Academy, New London, Conn.

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Chase, Louis S., Capt. M.C., Station Hospital, Westover Field, Mass.  
 Chiles, Daniel D., U. S. Public Health Service Hospital, Ft. Worth, Texas.  
 Cotton, John M., Lt. Col. M.C., Foster General Hospital, Jackson, Miss.  
 Crank, Henry H., Lt. Comdr. M.C., Receiving Unit, Annex, U. S. N. T. S. Farragut, Idaho.  
 Cruvant, Bernard A., Maj. M.C., Hd. Engineer Replacement Training Center, Ft. Belvoir, Va.  
 Des Rochers, Jean B., Veterans Administration Hospital, Roanoke, Va.  
 Friend, Maurice R., 1133 Park Avenue, New York City, N. Y.  
 Frignito, Nicholas G., Philadelphia State Hospital, Philadelphia, Pa.  
 Goldstein, Joseph L., Major M.C., Station Hospital, Camp Stewart, Ga.  
 Gralnick, Alexander, Central Islip State Hospital, Central Islip, N. Y.  
 Greenwood, Edward D., Capt. M.C., Station Hospital, Camp Carson, Colorado Springs, Colo.  
 Huston, Paul E., Psychopathic Hospital, Iowa City, Iowa.  
 Kelly, Francis W., Capt. M.C., Station Hospital, Kelly Field, Texas.  
 Kerman, Edward F., Springfield State Hospital, Sykesville, Md.  
 Kravetz, Irwin, Veterans Administration Facility, Chillicothe, Ohio.  
 Leet, Halbert H., Capt. M.C., La Garde General Hospital, New Orleans, La.  
 Loehner, Conrad A., Capt. M.C., 105th Evacuation Hospital, Camp Cooke, Calif.  
 Malmstead, Chester W., Veterans Administration Facility, Kecoughton, Va.  
 Moore, Kenneth G., Lt. Col. M.C., 304 S. Green St., Henderson, Ky.  
 Moriarty, John D., Lt. J.G., U. S. Naval Hospital, Mare Island, Calif.  
 Nieman, Roland E., Office of the Division Surgeon, 103rd Infantry Div. A.P.O. 470, Camp Howze, Texas.  
 Ostfield, John R., 54½ Broadway, Fargo, N. Dak.  
 Ozawa, Walter M., Territorial Hospital, Kaneohe, Oahu, T. H.  
 Paschkes, Erich, Manteno State Hospital, Manteno, Ill.  
 Paster, Samuel, Maj. M.C., Kennedy General Hospital, Memphis, Tenn.  
 Pisetsky, Joseph E., Veterans Administration Facility, Sheridan, Wyo.  
 Pumpian-Mindlin, Eugene, Capt. M.C., Station Hospital, Ft. McClellan, Ala.  
 Robbins, Lewis L., Capt. M.C., Mental Hygiene Unit, Drew Field, Tampa 7, Fla.  
 Rosen, Victor H., Capt. M.C., 98th General Hospital, Ft. Jackson, S. C.  
 Sampliner, Robert B., Capt. M.C., 36th Station Hospital, A.P.O. 649, c/o Postmaster, New York City, N. Y.  
 Schultze, Joseph H., Capt. M.C., A.P.O. 931, c/o Postmaster, San Francisco, Calif.  
 Silverman, Samuel, Capt. M.C., Nichols General Hospital, Louisville 2, Ky.

Suratt, Theodore P., Capt. M.C., Station Hospital, Camp Maxey, Texas.  
 Tissenbaum, Morris J., Norwich State Hospital, Norwich, Conn.  
 Vatz, Jack A., Pontiac State Hospital, Pontiac, Mich.  
 Walsh, William V., Veterans Administration Facility, N. Little Rock, Ark.  
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## MEMBERSHIP

Abrahamsen, David, 25 E. 86th St., New York, N. Y.  
 Adam, Alan Brown, Capt., Nashville Army Center, Nashville, Tenn.  
 Adams, Reta, Independence State Hospital, Iowa.  
 Alamprese, Donato J., 1226 13th Ave., Altoona, Pa.  
 Alexander, Eugene J., Station Hospital, Camp Polk, La.  
 Appel, John W., Capt. M.C., 1818 "H" Street, N. W., Washington, D. C.  
 Apter, Nathaniel S., Henry Phipps Psych. Clinic, Baltimore 5, Md.  
 Auerback, Alfred, 450 Sutter Street, San Francisco 8, Calif.  
 Austin, Florence Olive, Patton State Hospital, Patton, Calif.  
 Bandler, Bernard, 82 Marlborough St., Boston, Mass.  
 Bedinger, Ada D., Butler Hospital, Providence, R. I.  
 Bell, Anita I., 239 Central Park West, New York, N. Y.  
 Bender, Morris B., Lt. Comdr. U. S. N. R., U. S. Naval Hospital, San Diego, Calif.  
 Bennett, Courtenay L., Capt. M.C., Drew Field Station Hospital Tampa, Fla.  
 Bernucci, Robert J., Capt. M.C., Station Hospital, Camp Livingston, La.  
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PRESIDENT STRECKER.—I should like to ask some-  
 one to move that these members in the various  
 classes of membership be elected to the association.

Motion made, seconded and carried.

PRESIDENT STRECKER.—They are therefore elected.  
 The Secretary will now make an announcement.

SECRETARY OVERHOLSER.—I should have an-  
 nounced, ladies and gentlemen, that this list has  
 been gone over carefully by the board of examin-  
 ers, the name of which you changed the other day  
 to the committee on admissions. It has been re-  
 viewed by the Council and all the names of these  
 persons named on the list have been recommended  
 by the Council as well as by the board of examiners.

The Council will meet in the Green Room at  
 4.30 promptly this afternoon. There are several  
 items of business which, although brief, are im-  
 portant. The councillors who were elected at the  
 Tuesday morning meeting take office now and are  
 requested to attend the meeting this afternoon.  
 They replace those whose terms expired this year.

PRESIDENT STRECKER.—I now have the extremely  
 pleasant duty of handing over the affairs of this  
 Association for the next few moments to the Presi-  
 dent-elect, in a few minutes to become the President  
 of this association. I hand over the Association's  
 affairs with the greatest confidence. Not only is  
 the President-elect a friend of mine and I know  
 how his mind works, but he is an outstanding  
 representative of American psychiatry. We have, as  
 you know, gone to the west coast for our next  
 president, and I know that everyone will agree with  
 me that the Association is in safe, adequate and  
 skillful hands.

I would like to ask a former president of the  
 Association, Dr. Hall, and Dr. George Stevenson to  
 conduct the President-elect, Dr. Karl M. Bowman,  
 to the stage.

I give you, ladies and gentlemen, your new  
 President, Dr. Karl M. Bowman.

DR. KARL M. BOWMAN.—*Dr. Strecker, members  
 of the Association, and guests:* One appreciates  
 greatly this sign of confidence which the Associa-  
 tion has bestowed upon me by making me its presi-  
 dent for the next year. After one hundred years  
 the American Psychiatric Association, the oldest

national medical society in this country, has become  
 firmly established, has increased its membership  
 steadily, and is strong and vigorous.

I have talked with many members about the  
 affairs of the association and I find two points which  
 seem to me worth emphasizing. First, I find a  
 great deal of dissatisfaction with many things about  
 the Association, and a great deal of difference of  
 opinion as to what should be done to rectify matters.  
 Second, I find a great desire on the part of everyone  
 to be most helpful in straightening out the affairs  
 of the Association in every possible way.

I regard these two things as most healthy signs.  
 If we were all satisfied with the way the Association  
 is progressing, if we were all settling back calmly,  
 we would be in danger, as Dr. Gregg challenged us  
 yesterday when he said, "Will you become fat,  
 oracular and pontifical?" It seems to me we are  
 in no danger of that because I find that our mem-  
 bership is keenly alive to all the problems which  
 we have to deal with, dissatisfied that we are not  
 doing a better job and anxious to help in every way  
 so that we *can* do a better job.

Dr. Gregg said several things yesterday in criti-  
 cism of us, and I think we all accept his criticism.  
 I agree that in the future we must be more aggres-  
 sive and we must be more articulate. As you  
 remember, Dr. Gregg said those were two defects  
 of our Association.

We have already planned at the council meeting  
 that we will meet for three days next December  
 and attempt to work out specific plans for making  
 some of the improvements which many of our mem-  
 bers wish to see carried out. I think we feel that  
 we have now reached the point where either this  
 Association must assume leadership in matters  
 pertaining to psychiatry or others less qualified will  
 decide for us what we are to do and how psychiatry  
 is to develop. I believe that we are qualified to  
 assume this leadership and it is my hope that during  
 this next year we will assume still more leadership  
 than ever before.

Again I thank you for this honor which you  
 have conferred upon me.

PRESIDENT STRECKER.—President Bowman, my  
 good wishes go with you, and my sincere congratu-  
 lations are upon you.

Actually, and according to regulations, this an-  
 nouncement should be made by the new president,  
 Dr. Bowman, but I find that I still want to retain  
 enough grasp on the affairs of the Association to  
 make the announcement of the next program.

It seems this morning to be my good fortune to  
 relinquish the chair to men in whom I have the  
 greatest confidence, and with whom I have enduring  
 friendships: first to Dr. Bowman and now to Com-  
 mander Francis J. Braceland, who will preside over  
 the Navy program. Our psychiatrists in the Navy  
 will bring you word of how they have attempted to  
 solve their problems in the seven seas and the remote  
 corners of the world where the Navy has had such  
 outstanding and successful operations.

I hand over the chair to Commander Braceland.

Adjournment.

Alaba  
 Arizo  
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REGISTRATION FIGURES OF MEMBERS AND GUESTS ATTENDING  
THE 1944 CONVENTION IN PHILADELPHIA, PA.

States	Members	Guests	Total	States	Members	Guests	Total
Alabama .....	2	6	8	New York.....	228	251	479
Arizona .....	3	1	4	North Carolina.....	15	12	27
Arkansas .....	2	2	4	Ohio .....	23	24	47
California .....	25	29	54	Oklahoma .....	8	2	10
Colorado .....	8	6	14	Oregon .....	4	5	9
Connecticut .....	30	21	51	Pennsylvania .....	128	403	531
Delaware .....	4	2	6	Rhode Island.....	6	14	20
District of Columbia....	39	69	108	South Carolina.....	6	3	9
Florida .....	9	9	18	South Dakota.....	1	1	2
Georgia .....	18	9	27	Tennessee .....	10	10	20
Illinois .....	59	40	99	Texas .....	21	15	36
Indiana .....	10	8	18	Utah .....	3	1	4
Iowa .....	4	2	6	Vermont .....	4	3	7
Kansas .....	6	7	13	Virginia .....	31	32	63
Kentucky .....	10	8	18	Washington .....	3	1	4
Louisiana .....	9	6	15	West Virginia.....	3	6	9
Maine .....	1	...	1	Wisconsin .....	13	8	21
Maryland .....	50	63	113	Canada .....	33	31	64
Massachusetts .....	50	44	94	Porto Rico.....	1	...	1
Michigan .....	42	34	76	Mexico .....	1	2	3
Minnesota .....	13	2	15	Peru .....	...	1	1
Mississippi .....	4	4	8	England .....	...	1	1
Missouri .....	16	17	33				
Nebraska .....	7	6	13	Total .....	1,006	1,291	2,297
New Hampshire.....	7	4	11	Grand total.....			2,297
New Jersey.....	35	65	100				
New Mexico .....	1	1	2				

PROCEEDINGS SCIENTIFIC SESSIONS  
OF THE  
ONE HUNDREDTH ANNUAL MEETING  
OF THE  
AMERICAN PSYCHIATRIC ASSOCIATION

MAY 15-18, 1944

MONDAY MORNING, MAY 15, 1944

SECTION I

Dr. Edward A. Strecker presiding

Security of War Information. Maj. Albert J. Stowe.

Benjamin Rush. Prof. Richard H. Shryock.  
S. Weir Mitchell's Contribution to Neuropsychiatry. Dr. Beverley R. Tucker.

Dorothea Lynde Dix. Dr. George H. Stevenson.  
Concluding Remarks by Dr. Adolf Meyer.

SECTION II—INSULIN SHOCK THERAPY

Dr. Earl D. Bond presiding

Insulin Shock Therapy after Seven Years. Drs. Earl D. Bond and Thurston D. Rivers.

578 Schizophrenics Treated with Shock Therapy. Dr. John H. Taylor.

Delayed Action of Insulin in Schizophrenia. Comdr. F. J. Braceland, Drs. L. J. Meduna and J. A. Vaichulis.

A Seven Year Survey of Insulin Treatment in Schizophrenia. Dr. Alexander Gralnick.

Discussed by Drs. Titus H. Harris and Mr. Homer Folks.

SECTION III—JOINT SESSION WITH AMERICAN SOCIETY FOR RESEARCH IN PSYCHOSOMATIC PROBLEMS

Dr. Tracy J. Putnam presiding

Psychosomatic Disorders as Revealed by the Examination of Thirteen Million Registrants. Col. Leonard G. Rowntree.

The Prevalence of Chronic Disease. Dr. G. St. J. Perrott.

Criteria for Therapy in Psychosomatic Disorders. Drs. Flanders Dunbar and Jacob Arlow.

Discussed by Maj. Gen. George B. Chisholm, Lt. Col. William C. Menninger, Lt. Col. John D. Griffin and Miss Charlotte Carr.

SECTION IV—DISTURBANCES IN SLEEP

Dr. Eugen Kahr presiding

Somnambulism in the Armed Forces. Maj. S. A. Sandler.

The Sentinel Asleep on Post. Maj. Max Levin.  
Sodium Chloride Intake in Insomnia. Dr. Michael M. Miller.

Discussed by Drs. George S. Sprague and Louis H. Cohen.

MONDAY AFTERNOON, MAY 15, 1944

SECTION I—JOINT SESSION OF THE SECTION ON PSYCHOANALYSIS AND THE AMERICAN PSYCHOANALYTIC ASSOCIATION

Dr. Philip Lehrman presiding

The Contribution of Psychiatry to Psychoanalysis. Dr. Leo H. Bartemeier.

Psychoanalysis in the Psychiatric Hospital. Dr. Robert P. Knight.

Psychology in War Conditions. Dr. Ernest Jones.  
Executive Session, Section on Psychoanalysis.

SECTION II—JOINT SESSION OF THE SECTION ON PSYCHOPATHOLOGY OF CHILDHOOD AND THE AMERICAN ASSOCIATION ON MENTAL DEFICIENCY

Dr. Frederick H. Allen presiding

Psychiatry and Children's Problems: A Brief History. Dr. Lawson G. Lowrey. Discussed by Dr. Joseph E. Nowrey.

Mental Disease Among Mental Defectives. Dr. Horatio M. Pollack. Discussed by Dr. C. Stanley Raymond.

Schizophrenic-Like Reactions in Children. Drs. Leon N. Goldensohn, Dr. Ed. R. Clardy and Kate N. Levine. Discussed by Dr. Groves B. Smith.

Psychic Trauma of Operations in Children. Dr. David M. Levy. Discussed by Dr. Norvelle C. Lamar.

Common Syndromes in Child Psychiatry. Drs. R. L. Jenkins and Sylvia Glickman. Discussed by Dr. Leo Kanner.

SECTION III—SECTION ON CONVULSIVE DISORDERS

Dr. William G. Lennox presiding

Business Session of Section on Convulsive Disorders of the American Psychiatric Association.

History of the Section on Convulsive Disorders and Related Efforts. Dr. G. Kirby Collier.

A Follow-up Study on 70 Former College Students Subject to Convulsive Disorders. Drs. Leonard E. Himler and Theophile Raphael.

The Epileptic in the Army. Capt. Ephraim Roseman.

Nymphomania as a Cortical Epileptiform Discharge. Dr. Theodore C. Erickson.

The Mentality of Normal and Epileptic Twins. Drs. William G. Lennox and A. L. Collins.

Convulsive States and Coma in Cases of Islet Cell Adenoma of the Pancreas. Drs. Paul F. A. Hoefer, Samuel A. Guttman and Irving J. Sands.

Clinical and Electroencephalographic Studies of Changes in Cerebral Function Associated with Variations in the Blood Sugar Level. Drs. Israel Strauss and Israel S. Wechsler.

The Benefits of Routine Physical Training in the Epileptic. Dr. Temple Fay.

Fatigue as a Precipitating Factor in Latent Epilepsy. Dr. Max. H. Weinberg.

#### SECTION IV—SECTION ON FORENSIC PSYCHIATRY

Dr. Frank J. Curran presiding

Isaac Ray, Psychiatrist and Pioneer in Forensic Psychiatry. Capt. A. Warren Stearns.

Current Problems in Medico-Legal Testimony. Drs. Gustav Bychowski and Frank J. Curran. Discussed by Dr. David Abrahamsen.

Teen Age Murderers. Dr. Ralph S. Banay. Discussed by Dr. R. L. Jenkins.

Aggression in the Girl Delinquent. Dr. S. Harvard Kaufman. Discussed by Dr. Lowell S. Selling.

A Study of Motivations for Desertions and Over-Leaves in the Navy. Lt. Comdr. Walter Bromberg, Lt. Anthony A. Apuzzo and Lt. Bernard Locke. Discussed by Lt. Comdr. James M. Henninger and Comdr. Francis J. Braceland.

TUESDAY MORNING, MAY 16, 1944

#### SECTION I—PSYCHIATRY AND THE UNITED STATES ARMY

Lt. Col. William C. Menninger presiding.

The Over-All Picture of Mental Health in the Army. Lt. Col. Malcolm J. Farrell and Capt. John W. Appel.

The Treatment of Functional Disabilities in Army Hospitals. Lt. Col. Lauren H. Smith.

Preventive Psychiatry with Combat Soldiers. Capt. Herbert X. Spiegel.

Military Efficiency in Relation to Attitudes. Maj. S. H. Kraines.

War Neuroses and Their Treatment in the African-Italian Theater of Operations. Lt. Col. Roy R. Grinker and Maj. John P. Spiegel.

War Neuroses Among Flying Personnel in the English Theater of Operations. Maj. Donald W. Hastings.

Discussed by Col. Franklin G. Ebaugh, Lt. Col. Douglas A. Thom and Dr. Arthur H. Ruggles.

#### SECTION II—EXPERIMENTAL STUDIES

Dr. R. G. Hoskins presiding.

Electroencephalographic Studies in Psychoneurotic Patients. Drs. Mary A. B. Brazier, Stanley Cobb and Jacob E. Finesinger.

Integration of the Electroencephalogram. II. A Suggested Approach to the Psychoses through Electroencephalography. Drs. Wm J. Turner and Charles S. Roberts.

Discussed by Dr. Hudson Hoagland.

Neurosis and Alcohol—An Experimental Study. Dr. Jules H. Masserman. Discussed by Dr. W. Horsley Gantt.

The Carbohydrate Tolerance of Mentally Disturbed Soldiers. Drs. H. Freeman, E. H. Rodnick, D. Shakow and T. Lebeaux. Discussed by Dr. Edwin F. Gildea.

Cerebral Metabolism in Patients with Depression. Drs. Harold E. Hinwick, D. Ewen Cameron, Edmund Homburger, and Fred Feldman. Discussed by Dr. S. Katzenelbogen.

#### SECTION III—ORGANIC STUDIES

Dr. Bernard J. Alpers presiding

Prefrontal Lobotomy in Schizophrenia. Drs. Walter Freeman and James W. Watts.

Pre-Frontal Lobotomy: 15 Patients Before and After Operation. Drs. Josef A. Kindwall and David Cleveland.

Discussed by Dr. David C. Wilson.

Pathology of the Liver in Extrapyramidal Disease. Drs. G. Heilbrunn, O. Felsenfeld and P. B. Szanto. Discussed by Dr. Walter L. Bruetsch.

Psychiatric Manifestations of Certain Nonstructural Cerebrovascular Disorders. Drs. R. W. Waggoner and N. Malamud. Discussed by Dr. N. W. Winkelman.

Studies of the Corpus Callosum: Diagnostic Dyspraxia Following Section of the Corpus Callosum. Lt. Comdr. Andrew J. E. Akelaitis. Discussed by Dr. Paul I. Yakovlev.

TUESDAY AFTERNOON, MAY 16, 1944

#### SECTION I—PSYCHIATRY AND THE U. S. PUBLIC HEALTH SERVICE

Dr. Lawrence Kolb presiding

Selective Service Violators. Drs. C. G. Southard and J. R. Hurley.

An Integrated Medico-Psychological Program at the U. S. Coast Guard Academy. I. Preliminary Reports. Drs. Robert H. Felix, Dale C. Cameron, Lt. Joseph B. Bobbitt and Lt. Sidney H. Newman.

Psychological First Aid. Drs. Daniel Blain, Paul Hoch and V. Gerard Ryan.

Review of Cases at Merchant Marine Rest Centers. Drs. Florence Powdermaker, William A. Bellamy and Joseph Wortis.

The Use of Drugs in the Treatment of Traumatic War Neuroses. Drs. Robert Heath and Stephen Sherman.

The Work-Recreation Approach to Occupational Therapy. Drs. Clifford D. Moore and Walter R. Bonime.

Discussed by Drs. Abraham Myerson, Howard W. Potter, Marion R. King and Maj. W. E. Barton.

#### SECTION II—PSYCHONEUROSES

Dr. John C. Whitehorn presiding

Cardiovascular Findings in a Group of Neurocirculatory Asthenia Cases. Drs. H. R. Rothman and M. E. Fox. Discussed by Dr. Mandel Cohen.

Social Anxiety Neurosis—Its Possible Relationship to Schizophrenia. Dr. Abraham Myerson. Discussed by Dr. L. E. Hinsie.

Aftermath of Operational Fatigue in Combat Aircrews. Maj. Milton L. Miller. Discussed by Dr. W. L. Woods.

A Psychiatric and Rorschach Study of Adult Male Enuresis. Maj. George S. Goldman and Corp. Martin S. Bergman. Discussed by Dr. Hugh T. Carmichael.

Post-Traumatic Neuroses. Dr. Alexandra Adler. Discussed by Dr. J. G. Lynn.

Neurotic Reactions in Wives of Service Men. Dr. Ralph M. Patterson. Discussed by Maj. D. Rothschild.

#### SECTION III—ADMINISTRATIVE PSYCHIATRY

Dr. H. K. Petry presiding

Post-Graduate Psychiatric Nursing. Mrs. Laura W. Fitzsimmons. Discussed by Dr. J. D. Mulder.

Psychiatric Internship. Drs. Grosvenor B. Pearson and Kathryn L. Schultz. Discussed by Col. Franklin G. Ebaugh.

The Psychiatric Problem of Suicide. Dr. James H. Wall. Discussed by Dr. Sandor Rado.

An Analysis of Illinois Mental Hospital Admissions, 1922-1942. Drs. Conrad Sommer and H. H. Harmon. Discussed by Dr. Neil A. Dayton.

Age of Onset and Sex in Familial Mental Illness. Dr. Lionel S. Penrose. Discussed by Dr. Edgar C. Yerbury.

#### TUESDAY EVENING, MAY 16, 1944

##### ROUND TABLE DISCUSSIONS

Administrative Psychiatry. Moderator: Dr. Clifton T. Perkins. Discussed by Drs. Frederick MacCurdy, Harry C. Solomon and Mr. Charles C. Cain, Jr.

Child Psychiatry. Moderator: Dr. Frederick H. Allen. Discussed by Drs. Leo Kanner, William Healy, Edgar C. Yerbury, Louis A. Lurie and Edward J. Humphreys.

Civilian Utilization of War Fostered Trends. Moderator: Dr. D. Ewen Cameron. Discussed by Lt. Col. Roy R. Grinker, Col. W. Line, Lt. Col. Martin A. Berezin, Drs. Daniel Blain, Richard Brickner and Erich Lindemann.

Group Psychotherapy. Moderator: Dr. Roscoe W. Hall. Discussed by Drs. Nathan W. Ackerman, Lauretta Bender, Comdr. Francis J. Braceland, Lt. Col. R. Robert Cohen, Drs. Maxwell Gitelson, Samuel B. Hadden, Lt. Comdr. Herbert Harris, Frances Herriott, Drs. Abraham A. Low, Jacob L. Moreno, Maj. Samuel Paster, Drs. Stephen Sherman, Bruno Solby, Alfred P. Solomon and Louis Wender.

Industrial Mental Hygiene and Psychiatry. Moderator: Dr. Frank F. Tallman. Discussed by Drs. G. A. Eadie, Edgar C. Yerbury, L. E. Himler, K. E. Markuson and Victor Reuther.

Occupational Therapy. Moderator: Dr. Conrad S. Sommer. Discussed by Drs. Wm. R. Dunton, Jr., Joseph R. Blalock, H. C. Dunstone, Everett S. Elwood and Miss Margery Fish.

Psychiatric Nursing: Past, Present and Future. Moderator: Dr. Charles P. Fitzpatrick. Discussed

by Dr. Ross McC. Chapman, Miss Mary Corcoran, Miss Elizabeth Bixler and Mrs. Laura W. Fitzsimmons.

Psychopathic Personality. Moderator: Dr. Robert A. Mathews. Discussed by Drs. Hervey M. Cleckley, Gerald H. J. Pearson, Joseph Hughes, Harold D. Palmer and William Malamud.

The Military Problem of Malingering. Moderator: Maj. Benjamin H. Balser. Discussed by Lt. Col. Herman L. Blumgart, Lt. Comdr. John T. Eads and Lt. Comdr. C. L. Wittson.

#### WEDNESDAY MORNING, MAY 17, 1944

Dr. Edward A. Strecker presiding

Psychological Adjustment of Soldiers to the Army and to Civilian Life. Maj. Gen. George B. Chisholm.

Group Attitudes and Their Effects on Communications. Prof. T. North Whitehead.

A Critique of Psychiatry. Dr. Alan Gregg.

#### WEDNESDAY AFTERNOON, MAY 17, 1944

Mr. Benjamin Rush, Jr. presiding

Presidential Address

Reports of Special Committees

Dr. Edward A. Strecker presiding

Hospital Administration. Committee: Drs. S. W. Hamilton, W. A. Bryan and Charles Read.

Mental Hygiene. Committee: Drs. George S. Stevenson, Arthur H. Ruggles and George H. Preston.

Psychoanalysis. Committee: Drs. A. A. Brill, John C. Whitehorn and Karl A. Menninger.

Psychotherapy. Committee: Drs. Harry Stack Sullivan, Frederick H. Allen and Oskar Diethelm.

Shock Therapy. Committee: Drs. Nolan D. C. Lewis, Harry C. Solomon and A. E. Bennett.

International Psychiatry. Committee: Dr. Glenn E. Myers.

Some Objective Studies of Rhythm in Music. Prof. Howard Hanson.

#### THURSDAY MORNING, MAY 18, 1944

##### SECTION I—PSYCHIATRY AND THE U. S. NAVY

Comdr. Francis J. Braceland presiding

Address. Surg. General Ross T. McIntire.

Psychiatric Aspects of Amphibious Warfare. Lt. Comdr. Clarence C. Hare.

Psychiatric Practice Aboard a Hospital Ship in a Combat Area. Lt. Comdr. Dana L. Farnsworth and Lt. Robert S. Wigton.

Psychological and Psychiatric Reactions in Diving and Submarine Warfare. Comdr. A. R. Behnke.

Group Psychotherapy in War Neuroses. Lt. Comdr. Louis A. Schwartz.

Treatment of Combat Induced Emotional Disorders in a General Hospital within the Continental Limits. Comdr. G. N. Raines and Lt. L. C. Kolb.

Military Group Psychotherapy. Lt. Howard P. Rome.

Discussed by Drs. Karl M. Bowman, Earl D. Bond and David A. Boyd.

#### SECTION II—CONVULSIVE SHOCK TREATMENT

Dr. Walter L. Treadway presiding

The Effects of Electro Shock Therapy on the Electroencephalogram. Drs. R. W. Howell, B. K. Bagchi and Herbert Schmale.

Clinical and Electro-Physiological Observations Following Electroshock. Drs. Lorne D. Proctor and John E. Goodwin.

A Comparative Study and Evaluation of Electro Shock Therapy in Depressive States. Drs. Kenneth J. Tillotson and Wolfgang Sulzbach.

Convulsive Therapy (Metrazol and Electrical) in the Affective Psychoses. A controlled series covering a five year period. Drs. Eugene Ziskind, Esther Somerville-Ziskind and Louis Ziskind.

Atypical Post Metrazol Status Epilepticus. Dr. J. A. Cummins.

Electronarcosis—A Therapy in Schizophrenia. Drs. Esther Bogen Tietz, George N. Thompson, A. Van Harreveld and C. A. G. Wiersma.

The Correlations of the Results of Sodium Amytal Narcosis and of Convulsive Shock Treatment. Drs. Robert A. Clark, Martin J. Gerson and Rodney H. Kiefer.

The Organic Psychotic Syndromes Occurring During Electric Convulsive Therapy. Dr. Lothar B. Kalinowsky.

Spontaneous Convulsions Following Convulsive Shock Therapy. Drs. B. L. Pacella and S. E. Barrera.

Extra Mural Electric Shock Therapy. Dr. Paul Homer.

Healing Mechanisms in the Shock-Treated Neurotic Patient. Lt. John D. Moriarty and Dr. Andre A. Weil.

Discussed by Drs. S. Bernard Wortis, Harold D. Palmer and A. E. Bennett.

#### SECTION III—MORALE

Lt. Col. Douglas A. Thom presiding.

Prophylactic Group Psychotherapy in a Replacement Training Center. Maj. N. J. Berkwitz. Discussed by Dr. Theophile Raphael.

Psychiatric Reflections on Some Current Social-Political Dogmas. Dr. Kenneth E. Appel. Discussed by Dr. Harry Stack Sullivan.

Psychiatric Problems in Naval Personnel. Surg. Lt. Comdr. M. Wellman. Discussed by Lt. Manuel Pearson.

The Psychic Trauma of Becoming Part of a Group. Dr. Horace G. Miller. Discussed by Dr. Kenneth J. Tillotson.

A Mental Hygiene Program for the Military Hospital. Maj. Louis S. Lipschutz and Rebecca Rosen. Discussed by Maj. Henry B. Elkind.

THURSDAY AFTERNOON, MAY 18, 1944

#### SECTION I—REHABILITATION

Dr. Karl M. Bowman presiding

The Reconditioning and Rehabilitating Program in Army Hospitals. Maj. Walter E. Barton.

Rehabilitation of Discharged Soldiers. Dr. B. Liber.

Unconscious Malingering vs. Rehabilitation. Dr. John W. Turner.

Psychiatric Rehabilitation Therapy. Dr. Thomas A. C. Rennie.

The Challenge of World War II Veterans Discharged with N. P. Diagnoses to Psychiatry. Dr. Charles B. Huber.

Discussed by Lt. Howard P. Rome and Dr. William Malamud.

Adjournment.

#### SECTION II—PSYCHOSOMATIC STUDIES

Dr. Stanley Cobb presiding

The Symptomatology and Management of Grief Reactions. Dr. Erich Lindemann. Discussed by Dr. John Romano.

Liaison Psychiatry and the Pediatric Outpatient Department. Drs. Reynold A. Jensen and John M. Adams. Discussed by Dr. Leo Kanner.

Heart Consciousness in Canadian Recruits. Maj. T. E. Dancey, Maj. P. Lariviere and Capt. W. D. Ross.

Cardiac Changes in Emotion. Drs. Thomas A. Loftus, Harry Gold and Oskar Diethelm.

Discussed by Dr. George E. Daniels.

Hypnotic Techniques for the Therapy of Acute Psychiatric Disturbances in War. Dr. Milton H. Erickson. Discussed by Dr. Erich Lindemann.

#### SECTION III

Dr. Harry A. Steckel presiding

Personalities of American Psychotherapists. Drs. Margaret C. L. Gildea and Edwin F. Gildea. Discussed by Gregory Zilboorg.

The Developmental Roots of Schizophrenia. Dr. J. S. Kasanin. Discussed by Dr. Howard W. Potter.

Three Years of Naval Selection—A Retrospect. Lt. Comdr. C. L. Wittson and Lt. Comdr. W. A. Hunt.

Reorganization of Personnel Functions in the Army, as the Basis for Improvement in Selection Procedures. Dr. Lawrence S. Kubie.

A Study of the High Psychiatric Rejection Rate Among Selective Service Examinees from Georgia. Capt. Morton L. Wadsworth and Comdr. Paden E. Woodruff.

A Socio-Psychological Survey of 300 Men Rejected for Military Service. Lt. Col. Roscoe W. Cavell and Dr. Marion J. Fitzsimmons.

Discussed by Lt. Col. Douglas A. Thom, Comdr. Elmer Klein and Lt. Col. Wilfred Bloomberg.

## REPORTS OF COMMITTEES

The following reports of Committees and of the Secretary-Treasurer were presented to the Association and approved by it during the Centenary convention sessions in Philadelphia, Penna., May 15-18, 1944.

### REPORT OF THE EXECUTIVE COMMITTEE, HELD IN THE HOTEL BELLEVUE STRATFORD, PHILADELPHIA, PA. MAY 14, 1944

The Executive Committee of The American Psychiatric Association met in the Green Room of the Bellevue Stratford Hotel, Philadelphia, Pa., May 14, 1944, being called to order by the President, Dr. Edward A. Strecker, at 3.25 p. m. In addition to the President, there were present: Drs. Bowman, Thom, Ruggles and Overholser, and the Executive Assistant Mr. Davies.

It was voted, on motion of Dr. Ruggles, seconded by Dr. Thom, that the minutes of the December meetings of the Executive Committee and the Council be approved.

It was voted, on motion of Dr. Ruggles, seconded by Dr. Bowman, to recommend to the Council that not less than three days be set aside for meetings of the Executive Committee and Council in December 1944.

The matter of the meeting place for 1945 was considered. The Executive Assistant reported that on account of the War New Orleans would be unable to offer adequate accommodations, but that Chicago and New York would be able to. It was voted on motion of Dr. Overholser, seconded by Dr. Bowman, to recommend that Chicago be selected for the Annual Meeting of the Association in 1945.

The application of the New Orleans Society of Neurology and Psychiatry for recognition as an affiliated society was considered. It was voted, on motion of Dr. Overholser, seconded by Dr. Strecker, to recommend to the Council the approval of the application.

It was voted, on motion of Dr. Ruggles, seconded by Doctor Bowman, to recommend to the Council that the study of plans for a permanent home for the Association be further considered and expedited by the Executive Committee as rapidly as possible.

It was voted, on motion of Dr. Ruggles, seconded by Doctor Thom, to lay on the table the invitation of the "One Hundred Years Association" to The American Psychiatric Association to become a member.

It was voted, on motion of Dr. Thom, seconded by Dr. Bowman, to leave to the Executive Assistant the selection of a Certified Public Accountant to audit the accounts of the Association.

It was voted, on motion of Dr. Ruggles, seconded by Dr. Overholser, to provide copies of the Centennial Song, written by Mr. Davies, to the membership of the Association present at the meeting free of charge.

The meeting adjourned at 4.15 p. m.

WINFRED OVERHOLSER, M. D.,  
*Secretary-Treasurer.*

### REPORT OF THE MEETING OF THE COUNCIL HELD IN THE HOTEL BELLEVUE STRATFORD PHILADELPHIA, PA., MAY 14, 1944

The meeting of the Council was called to order by the President, Dr. Edward A. Strecker, at 4.20 p. m. in the Green Room of the Hotel Bellevue Stratford, Philadelphia, Pa.

The following were present:

Councillors: Drs. Strecker, Bowman, Overholser, J. K. Hall, R. W. Hall, Harris, K. A. Menninger, Ratliff, Reichard, Ruggles, G. H. Stevenson, Treadway, Waggoner, Young.

Past Presidents: Drs. Chapman, Russell, Sandy.

Chairmen of Committees: Drs. Allen, Bond, Burlingame, Ebaugh, Dayton, Fitzpatrick, Hamilton, Kenworthy, Glenn Myers, Myerson, Tarumianz, Steckel, Vernon, Zilboorg.

Representatives of Affiliated Societies: Drs. Gerty (Illinois), Owensby (Southern), Burkes (North Pacific), Chambers (Massachusetts), Maeder (Pennsylvania), Sprague (Kentucky), Romano (Cincinnati), Luce (Michigan), Griffin (Connecticut).

The representatives of the Affiliated societies were welcomed by Dr. Strecker.

It was voted, on motion of Dr. Stevenson, seconded by Dr. Bowman, to approve and accept the minutes of the meetings of the Executive Committee and Council held in December 1943.

The report of the Executive Committee held immediately preceding the meeting of the Council was presented by the Secretary, Dr. Overholser, and was accepted on motion of Dr. Waggoner, seconded by Dr. Stevenson.

It was voted, on motion of Dr. Harris, seconded by Dr. Waggoner, to accept the recommendation of the Executive Committee that the Annual Meeting in 1945 be held in Chicago, Ill.

It was voted, on motion of Dr. Young, seconded by Dr. Reichard, that the December meeting of the Council be extended to not less than three days.

It was voted, on motion of Dr. Ruggles, seconded by Dr. Bowman, that the New Orleans Society of Neurology and Psychiatry, on their petition presented as prescribed by the By Laws, be recognized as an affiliated society.

It was voted on motion of Dr. Waggoner, seconded by Dr. Young, that copies of the Centennial Song be distributed to members at the meeting without charge.

It was voted, on motion of Dr. Menninger, seconded by Dr. Ratliff, that advertising space be sold in the front pages of the JOURNAL.

It was voted, on motion of Dr. Ratliff, seconded by Dr. Young, that the Executive Committee continue and expedite its investigation concerning a

permanent home for the Association in New York City.

The Secretary, Dr. Overholser, read letters of congratulation from the Royal Medico-Psychological Association of Great Britain, and a cable of congratulation from Brig. J. R. Rees of the British Army Medical Corps. He also reported on the recent tour of the United States and Canada made by Dr. Walter S. Maclay of Mill Hill Emergency Hospital, London, under the auspices of the Association, and read letters from the London County Council and the British Ministry of Health expressing appreciation of the courtesies extended to Dr. Maclay.

The reports of the Secretary-Treasurer and Executive Assistant and the budget for 1944-45 were read and accepted.

The report of the Special Committee on Psychiatry in the Armed Forces was read by Dr. Ruggles. It was voted, on motion of Doctor Overholser, seconded by Dr. Bowman, that the report be accepted and that it be read in one of the open sessions of the Association. It was also voted, on motion of Dr. R. W. Hall, seconded by Dr. Harris, that the Committee be continued and that Dr. Bowman be added as a member.

The report of the Committee on Arrangements was presented by Dr. F. H. Allen, Chairman. The thanks and appreciation of the Council for the work of the committee were expressed by President Strecker.

Dr. Zilboorg reported for the Editorial Board of the Centenary Volume. A vote of thanks and deep appreciation of the work of the Board in their outstanding achievement in the preparation of the volume was passed, on motion of Dr. Ruggles, seconded by Dr. Strecker.

It was voted, on motion of Dr. Overholser, seconded by Dr. Ruggles, that the Editorial Board, having completed their assignment, be discharged.

Dr. Zilboorg also reported for the Committee on the History of Psychiatry. It was voted to accept the report, on the motion of Dr. Overholser, seconded by Dr. J. K. Hall, including the authorization to expend \$300 on the annual budget and also \$500 of the earmarked funds on a special project if approved by the committee.

The meeting suspended at 6.10 p. m. in order to inspect the historical exhibit prepared by Dr. Bookhammer and to have dinner, reconvening at 8.10 p. m.

Dr. Myerson presented the report of the Committee on Research. He announced that the Committee had awarded the Devereux Prize of \$500 to William Goldfarb, Ph.D., of New York City, for an original paper entitled, "Effects of Psychological Deprivation in Infancy and Subsequent Stimulation." The committee recommended that the Association award a prize for research activities; this recommendation was referred to the Executive Committee on motion of Dr. Bowman, seconded by Dr. Ratliff. The report was voted accepted on motion of Dr. Bowman seconded by Dr. Stevenson.

The report of the Committee on War Psychiatry,

read by Dr. Steckel, was approved on motion of Dr. Waggoner, seconded by Dr. Ruggles.

Dr. Malamud presented the report of the Committee on Program. It was voted on motion of Dr. Treadway, seconded by Dr. Waggoner, to accept the report and to express confidence in the committee and its functioning.

It was voted on motion of Dr. Bowman, seconded by Dr. Overholser, to authorize recording the proceedings of the Association, the recordings to be deposited in the Army Medical Library.

The report of the Board of Examiners was read by the Chairman, Dr. Hamilton. It was voted, on motion of Dr. Stevenson, seconded by Dr. Bowman, to accept the lists of associate members, members, corresponding and honorary members, and the various transfers, as read. On further discussion of the report, it was moved by Dr. Bowman and seconded by Dr. Harris that the names of the applicants deferred be read to the Council. The motion was lost. (Lists as accepted will be found in the proceedings of the Association.)

Doctor Burlingame reported for the Committee on Public Education. The report was accepted on motion of Dr. Ratliff, seconded by Dr. Harris, the committee to work along the lines suggested in their report with the full confidence of the Council.

Doctor Tarumianz reported for the Committee on Standards and Policies. Dr. Bowman moved, seconded by Dr. Overholser, that the committee's report be approved and that the subject matter be discussed in further detail at the December 1944 meeting of the Council. So voted.

The report of the Committee on Psychiatric Nursing was read by Dr. Fitzpatrick. Acceptance was voted on motion of Dr. Overholser, seconded by Dr. Bowman.

It was voted on motion of Dr. Overholser, seconded by Dr. Bowman, that the salary of Mrs. Laura Fitzsimmons, Nursing Consultant, be increased by \$500 to \$4800 annually.

The lists of those eligible for life membership, those in arrears, and those desiring to resign were read and approved.

It was voted, on motion of Dr. Ruggles, seconded by Dr. Bowman, to set the ceiling salaries for the office staff of the Association as follows, the Executive Committee to have authority to increase salaries within these figures:

Executive Assistant.....	\$7,000 per annum
First clerical assistant....	\$2,600 per annum
Second clerical assistant..	\$2,400 per annum

The meeting adjourned at 11.30 p. m., to reconvene at 4.30 p. m., Monday, May 15.

The Council reconvened at 4.30 p. m. May 15, 1944, in the Green Room of the Bellevue Stratford Hotel, Philadelphia, Pa., being called to order by President Strecker. The following were present: Drs. Strecker, Bowman, Overholser, J. K. Hall, R. W. Hall, Harris, Ratliff, Reichard, Ruggles, G. H. Stevenson, Treadway, Waggoner, Young, Past Presidents Chapman and Russell, Chairmen

Dayton, Fitzpatrick, Hamilton, Kenworthy, Glenn Myers.

The report of the Committee on Psychiatry in Medical Education was read by Dr. Ebaugh. It was adopted by vote on motion of Dr. Bowman, seconded by Dr. G. H. Stevenson. A letter from the Psychological Cinema Register of the Pennsylvania State College concerning the functions of the Register in providing instructional films was read and referred to Dr. Ebaugh with power to act, on motion of Dr. Overholser, seconded by Dr. Stevenson.

The following letter was read by the Secretary:

"May 14, 1944.

"To the President of the A. P. A., Dr. Edward A. Strecker:

"Upon the occasion of the one-hundredth anniversary meeting of The American Psychiatric Association, the members of the American Psychoanalytic Association and of the Section on Psychoanalysis of The American Psychiatric Association wish to tender their congratulations to their parent organization, in the happy reflection that almost two decades of friendly professional collaboration are included in this first one hundred years.

"For our part, we are proud to be the official partners and co-workers of this great Association whose catholic and progressive spirit so well becomes the responsibilities which have devolved upon it with especial seriousness in this time of world crisis.

LEO H. BARTEMEIER, M. D., *President*,  
American Psychoanalytic Association  
PHILIP R. LEHRMAN, M. D., *Chairman*,  
Section on Psychoanalysis, A. P. A."

It was voted, on motion of Dr. Overholser, seconded by Dr. Bowman, that the Secretary make suitable acknowledgement of this courteous communication.

Dr. Farrar reported as Editor of the JOURNAL, and announced the appointment of Dr. S. Spafford Ackerly to the Editorial Board. The report was accepted with congratulations to the Board on the fine Centennial Number, on motion of Dr. Overholser, seconded by Dr. Ratliff.

Dr. Dayton presented the report of the Committee on Nomenclature and Statistics. It was adopted on motion of Dr. Reichard, seconded by Dr. Treadway.

Dr. Kenworthy presented the report of the Committee on Psychiatric Social Service. It was voted, on motion of Dr. Ruggles, seconded by Dr. Overholser, to adopt the report for further discussion and consideration at the December meeting.

The report of the Committee on International Relationships was read by Dr. Glenn Myers. It was adopted on motion of Dr. G. H. Stevenson, seconded by Dr. Waggoner.

The Chairman of the Committee on Ethics, Dr. Vernon, reported for his committee. The report was ordered accepted and filed on motion of Dr. Overholser seconded by Dr. Bowman.

Dr. Strecker reported for the American Board of Psychiatry and Neurology, that the present diplomates (including those certified in May 1944) are as follows: In neurology 146, in psychiatry 992, in neurology and psychiatry 858. Total 1996. It was moved by Dr. Stevenson and seconded by Dr. Bowman that the report be approved with appreciation of Dr. Strecker's services. So voted.

On ballot of the members, it was voted to nominate Dr. Harold D. Palmer of Philadelphia to the American Board of Psychiatry and Neurology to serve on behalf of The American Psychiatric Association, succeeding Dr. Strecker.

The meeting adjourned at 6.30 p. m., to meet again on Thursday May 18th at 4.30 p. m.

The Council convened in the Green Room May 18, 1944, at 4.30 p. m., being called to order by Dr. Strecker. The following were present: Drs. Strecker, Bowman, Hamilton, Overholser, R. F. Gayle, J. K. Hall, Myers, Thom, Waggoner; Past President Chapman; Chairmen Malamud, Schroeder, Maeder; Doctor Chambers.

Dr. Schroeder presented the report of the Committee on Legal Aspects of Psychiatry. It was voted to accept the report, on motion of Dr. Bowman, seconded by Dr. Overholser.

A resolution relative to the importance of the psychiatric aspects of veterans' rehabilitation and the part which the Association should take in furthering a program was read by the Secretary and referred to the Executive Committee on motion of Dr. Bowman, seconded by Dr. Waggoner.

A resolution presented by Dr. Paul Wilcox regarding international relationships was referred to the committee of that name on motion of Dr. Thom, seconded by Dr. Gayle.

Dr. J. K. Hall moved a vote of thanks and appreciation to Dr. Gregory Zilboorg for his work in writing and producing the Centennial Play. This was seconded by Dr. Bowman, and voted.

Dr. Young moved that the American Board of Psychiatry and Neurology be notified that the Council would look with favor on a plan to examine overseas such candidates as are well qualified. This was seconded by Dr. J. K. Hall and so voted.

Dr. Maeder presented a report on behalf of the affiliated societies, which was referred to the Executive Committee on motion of Dr. Myers, seconded by Dr. Thom.

It was moved by Dr. Bowman and seconded by Dr. Overholser, that Drs. Strecker and Thom be elected to serve on the Executive Committee for the coming year. So voted.

The Council voted to approve the nominations to the Committee on Membership of Dr. Lawrence Kolb, Sr., for five years and of Dr. Joseph R. Blalock for one year, vice Dr. S. W. Hamilton, resigned.

Dr. Bowman assumed the chair, and the following resolution was offered by Dr. Waggoner:

"Resolved, That the Council register its recognition of the honor and services rendered to The

American Psychiatric Association by the significant and successful rôle taken by our retiring President, Dr. Edward A. Strecker, in the world of psychiatric affairs, particularly as regards the armed forces."

The resolution was seconded by Dr. J. K. Hall, and unanimously passed.

On motion of Dr. Overholser, seconded by Dr. Gayle, it was voted to ratify and confirm all acts and votes of the Executive Committee performed since the meeting of the Council in December 1943.

The meeting adjourned at 5.45 p. m.

WINFRED OVERHOLSER, M. D.  
*Secretary-Treasurer.*

#### REPORT OF TREASURER

##### STATEMENT OF INCOME AND EXPENSES

*For Period April 1, 1943, to March 31, 1944*

##### Income

##### Income—General Account:

Membership Dues—1943-1944 .....	\$23,431.42
Membership Dues—Prior to 1943 .....	750.40
Membership Dues—In Advance .....	195.50
Fellowship Certificates ...	200.00
Interest—Savings Accounts.	162.32
Interest—U. S. Government Bonds .....	375.00
Interest—Canadian Bonds.	97.50
Biographical Directory ...	412.59
Rent—Committee on Psychiatric Nursing .....	700.00
Section on Psychoanalysis.	62.65
<b>Total Income—General Account .....</b>	<b>\$26,387.38</b>

##### Income—AMERICAN JOURNAL OF PSYCHIATRY:

Subscriptions .....	\$10,022.21
Advertising .....	2,496.16
Back Numbers .....	885.46
Miscellaneous .....	108.50

**Total Income—JOURNAL Account .....** 13,512.33

##### Annual Meeting—Detroit, Mich.:

Annual Banquet Tickets...	\$1,632.00
Commercial Exhibits .....	1,154.90
Registration .....	666.00
Sale of Programs.....	16.65
Detroit Hotel Association.	710.50

**Total Income—Annual Meeting .....** 4,180.05

**Total Income .....** \$44,079.76

##### Expenses

##### Expenses—General Account:

Salary—Executive Assistant .....	\$4,658.26
Clerical Salaries .....	3,965.18
Bonuses Paid .....	600.00
Printing—Directory of Members .....	1,388.25
Other Printing .....	538.72
Committee Expenses (Schedule Attached) ...	2,716.51
Dues Refunded .....	68.00
Rent .....	1,717.20
Postage .....	694.99
Insurance and Annuities—Net .....	461.20
Old Age Benefits Expense.	66.27
Check Taxes .....	49.49
Traveling Expenses—A. M. Davies .....	165.39
Fellowship Certificates ...	58.35
Biographical Directory ...	53.72
Telephone and Telegrams..	81.54
Electric .....	70.70
Miscellaneous .....	402.81

**Total Expenses—General Account .....** \$17,756.58

##### Expenses—AMERICAN JOURNAL OF PSYCHIATRY:

Printing—through Volume 100—4 .....	\$10,993.02
Other Printing .....	107.16
Editorial Assistance .....	1,033.43
Rent—Canadian National Committee .....	200.00
Telephone and Telegraph..	261.54
Postage .....	200.77
Office Supplies .....	57.02
Mailing Back Numbers...	88.00
Miscellaneous .....	183.44

**Total Expenses—JOURNAL Account .....** 13,124.38

##### Expenses—Annual Meeting—Detroit, Mich.:

Commercial and Scientific Exhibits .....	\$331.41
Final Programs .....	660.54
Mailing Final Programs...	52.50
Annual Banquet .....	1,564.28
Orchestra—Banquet .....	179.00
Movies and Slides.....	68.25
Badges and Ribbons.....	113.67
Registration Cards, Tickets, etc. ....	35.12
Gift Scroll .....	55.00
Telephone and Telegraph..	55.35
Honorarium .....	100.00
Committee Expenses .....	92.46
Board and Council Dinners	113.03
Reporting Convention ....	89.85

Gifts and Page Boys.....	\$150.00
Traveling Expenses .....	347.57
Expressage .....	16.48
Total Expenses—Annual Meeting .....	4,024.51
Total Expenses .....	\$34,905.47
Excess of Income Transferred to Surplus .....	\$9,174.29

## SCHEDULE OF CASH BALANCES

March 31, 1944

	Book No.	Balance
Chase National Bank .....		\$4,124.05
Union Dime Savings Bank ...	1,115,778	4,331.15
Emigrant Industrial Savings Bank .....	137,048	4,346.50
Bowery Savings Bank .....	258,266	4,533.54
Total Cash Balances.....		\$17,335.24

## Net Cash Resources

American Psychiatric Association (as above) .....	\$17,335.24
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U. S. Government Defense Bonds.....	\$15,000.00
Canadian Government Bonds.....	3,057.00
AMERICAN JOURNAL OF PSYCHIATRY—Chase National Bank.....	5,364.39
Meeting Account—as per statement as of July 15, 1943.....	155.54
Net Resources Available.....	\$40,912.17

## Reconciliation of Surplus Account

Surplus, April 1, 1943.....	\$31,737.88
Excess of Income for Year Ended March 31, 1944.....	9,174.29
Surplus, April 1, 1944.....	\$40,912.17

Balances on Special Accounts as per audited statements—March 31, 1944:	
Committee on Psychiatric Nursing—Rockefeller Fund .....	\$3,786.74
Committee on History of Psychiatry—Special Fund .....	\$2,297.11

Respectfully submitted,

A. A. TUROFF,

Certified Public Accountant.

## ANALYSIS OF COMMITTEE EXPENSES

March 31, 1944

	Total	Clerical	Travel and meetings	Telephone, postage and printing	General
Executive .....	\$1,707.32	\$120.00	\$1,508.10	\$52.30	\$26.92
History of Psychiatry.....	57.34	....	....	29.64	27.70
Board of Examiners.....	61.87	....	....	61.87	....
Public Education .....	85.84	....	....	85.84	....
War Psychiatry .....	51.79	....	....	12.18	39.61
Program .....	488.07	106.21	259.14	78.47	44.25
Centenary .....	8.18	....	....	....	8.18
Psychiatric Nursing .....	60.56	25.00	....	13.83	21.73
Psychiatry in Armed Forces.....	149.87	....	149.87	....	....
Section on Psychoanalysis.....	15.05	....	....	15.05	....
Section on Forensic Psychiatry.....	13.33	....	....	13.33	....
Psychiatric Standards-Policies .....	4.47	....	....	4.47	....
Arrangements .....	8.53	....	....	8.53	....
Section Psychopathology of Childhood..	4.29	....	....	4.29	....
Totals .....	\$2,716.51	\$251.21	\$1,917.11	\$379.80	\$168.39

## REPORT OF THE EXECUTIVE ASSISTANT

Your Executive Assistant herewith submits his annual report:

As the financial report indicates, this has been the most satisfactory financial year since my connection with the Association. The balance of \$4,124.05 in the membership account is, I think, sufficient to recommend to the Executive Committee and Council that at least \$3,000.00 of this be transferred to reserve funds. The JOURNAL balance of \$5,364.39 was created by a subsidy of \$4,000.00 to the JOURNAL which should be sufficient to cover the expenses

for the special centennial number and for the March-April issue (Vol. 100, No. 5).

With the money on hand to pay for these two issues, the JOURNAL is now up to date in its payments and, beginning with the new fiscal year, should be able to go on a regular schedule of six issues with money sufficient to pay for them. The amount of subsidy assigned in the budget is reduced to \$3,000.00 because the revenue from subscriptions and advertising are increasing.

The contract approved by Council in December with the Medical Publications Bureau, I am happy to report, is working out successfully, resulting in

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\$383.00 in new advertising revenue for the January and March 1944 issues. The subscriptions now total 1,663, which is not only our largest number of subscriptions but shows an increase of 679 over last year of 984. The action of Council regarding reduced rates to medical students and internes have resulted in 25 subscriptions.

The sales of the Biographical Directory have been continued with the result that only \$55.64 balance is due to the Association and it looks hopeful that this will be completely liquidated. There are remaining at the binders 500 unbound copies but it does not seem possible to sell them due to the fact that the data is now pretty much out of date.

War conditions have imposed an unusual strain in preparing for the annual meeting. Material shortages, lack of normal assistance, and particularly the hotel room situation have been difficult. I wish to pay tribute to Dr. Allen and his Sub-Committee Chairmen for the masterful cooperation in helping solve the difficult problems, particularly that of hotel rooms. I am glad to report that the largest number of exhibits ever sold was sold for the centennial meeting. Thirty booths will produce a revenue of approximately \$3,500.00.

Your Executive Assistant has kept in regular touch with the President and Secretary and has tried to assist all the committees in performing their functions. The routine work of the office has continued to function through the efficient aid of Miss Rubenstein and Miss Borduk and the membership list and all other regular material has been produced on schedule.

AUSTIN M. DAVIES.

REPORT OF THE EDITORIAL BOARD OF THE CENTENARY VOLUME, "ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY," TO THE COUNCIL OF THE AMERICAN PSYCHIATRIC ASSOCIATION, SUBMITTED MAY 14, 1944

GENTLEMEN:

This is the final report of the Editorial Board, and it is therefore a petition for honorable discharge. The official date of publication of the Centenary Volume is May 14, 1944. This date will be met, since copies for distribution have been ready for some time.

There was no departure from our original editorial plans as far as the content of the volume was concerned, except for the one reported to you last December, and the addition of three chapters on military psychiatry. The appearance of the book, as far as its basic design was concerned, was not changed. Instead of the original 512 pages planned, there are 649. There would have been even more, but for purposes of economy the index was arranged in triple instead of double columns, and three additional lines were added to each page of the book. Fortunately, because the paper had been available for a long time before restrictions due to war conditions were imposed, the general layout of the book—such as size of pages and margins—was not affected.

The volume contains approximately 275,000 words. Two thousand copies were printed on ragston paper, which is watermarked "A.P.A. 1844-1944." In this number are included one hundred presentation copies bound in half leather, pages uncut.

By the time the book is put on the market only half of the edition will be available for sale, since about 900 prepaid orders were received before the publication date. We may note here in passing that advance orders were received not only from members and non-members of the Association in this country, but from various people and institutions abroad: From England, New Zealand, Mexico, Peru, and Argentina.

In the past year we have turned over to the Columbia University Press \$3,314.35—this in accordance with our contract and in addition to the \$2,500.00 originally paid to the Press as a subvention. At the final accounting, some of the moneys which have been handed over to the Press may be returned to the Association, of course. This is contingent upon whether the edition is sold out, and whether losses are sustained or profits accrue.

There were a number of smaller expenses which were incurred by the Editorial Board, and for which the Executive Assistant kept a careful record. Money for expenses was always drawn from the funds earmarked for the Committee on the History of Psychiatry. A detailed financial account is at present impossible, and will remain so until a complete auditing of our disbursements, as well as of the receipts and disbursements in connection with the volume on the part of the Columbia University Press, is available.

We submit that the final accounting be made by the Committee on the History of Psychiatry, as a part of the latter's functions, and that in due course of time a report of that audit be presented to the Council.

Of the 100 presentation copies, we now have 50 duly inscribed for proper distribution. The list of the recipients of these copies was made up by the Editorial Board and the Committee on the History of Psychiatry, in consultation with the offices of the Association. The presentation copies are all numbered. Copy number one was inscribed to the President of the United States; copy number two to the Surgeon General of the United States Army; copy number three to the Surgeon General of the United States Navy; copy number four to the Surgeon General of the United States Public Health Service; copy number five to the President of our Association, Dr. Edward A. Strecker. The remaining 45 copies at present inscribed are to be presented to the officers and officers-elect of the Association, to the members of the Editorial Board and the Committee on the History of Psychiatry, to the contributors to the Centenary Volume, and to the former presidents of the Association.

In this connection, we recommend that one presentation copy be inscribed to the Boston Medical Library in memory of Dr. Charles Macfie Campbell, who passed away so recently; on more than one occasion Dr. Campbell expressed great interest

in the Centenary Volume and was helpful with counsel to the Editorial Board.

A presentation copy has also been inscribed to Mr. Franklin B. Kirkbride, the son of the first Secretary and sixth President of the American Psychiatric Association; to the three artists who composed the jury for the selection of the winning sketch for our Centenary Emblem; to Dr. Alan Gregg, Director of the Division of Medical Sciences, Rockefeller Foundation; to Dr. N. Emmons Paine, the oldest member of the Association among us, and to others. In no case was more than one presentation copy inscribed to any one individual.

We recommend that the remaining presentation copies, numbers 51 to 100, be kept in the custody of the Committee on the History of Psychiatry, and that their disposal be decided upon in each individual case by the Committee on the History of Psychiatry, with the approval of the Council. It might be possible at a future date to formulate more fully the qualifications of a recipient of a presentation copy.

We recommend that twenty copies of the regular edition be acquired, thirteen to be given to the contributors to the volume (one to each), the remaining seven copies to be kept for special disposal in connection with various contingencies which may arise. One such contingency: Dr. Cecil L. Schultz, President of the Columbia County Medical Society, not a psychiatrist, spent a great deal of time and ingenuity in procuring a copy of the signature of one of the Original Thirteen, Dr. Samuel White. Dr. Schultz is not personally known to any member of the Editorial Board or the Committee on the History of Psychiatry; his cooperation was entirely due to his actual interest in our job. He undoubtedly deserves to receive a copy of the regular edition of the volume.

This concludes the factual report of our assignment. The Editorial Board wishes now to express its thanks to the American Association of the History of Medicine for its help and cooperation. We wish also to express our heartfelt thanks to the Council of the Association for their steadfast interest in and understanding of our work. And last but by no means least, we wish to thank the Executive Committee, Drs. George H. Stevenson and Arthur H. Ruggles—the initiators of our undertaking—and the American Psychiatric Association as a whole for the honor bestowed upon us by the assignment of this task.

Respectfully submitted,

J. K. HALL,

*General Editor,*

GREGORY ZILBOORG,

*Associate Editor,*

HENRY ALDEN BUNKER,

*Assistant Editor.*

#### REPORT OF THE CENTENARY COMMITTEE

The report of this committee, the results of its work, consists of the exercises for Centenary Day which are found in print in the program.

The committee has supported, has been supported by, the Program Committee and the different sub-

sections of the Committee on Arrangements. It has arranged for the appearances of Benjamin Rush, Jr., and Franklin B. Kirkbride to extend welcomes to the Association. Representatives of families of the Founders and of the Founding Hospitals have been invited to attend.

EARL D. BOND, *Chairman,*

THEODORE L. DEHNE,

ROBERT G. STONE,

\* LAUREN H. SMITH.

#### REPORT OF COMMITTEE ON ARRANGEMENTS

As I indicated in my report to the Council in January, the Arrangements Committee for the Centennial meeting was organized with wide representation of the members from Pennsylvania, New Jersey and Delaware along the following lines. There are two vice chairmen, Mr. Everett Elwood and Dr. Charles A. Zeller. The committee was subdivided into the following five committees: Committee on Finance, Dr. Harold D. Palmer; Committee on Exhibits, Dr. Robert S. Bookhammer; Committee on Hotels, Dr. LeRoy M. A. Maeder; Committee on Entertainment, Dr. O. Spurgeon English; Committee on Publicity, Dr. Robert A. Matthews; Women's Arrangement Committee, Mrs. Madeline Appel. Each of these committees has had members from the general committee working with them.

I want to take this occasion to express my sincere appreciation and praise for the fine job that these chairmen have carried out in preparation for this meeting. It has been a difficult year to arrange a meeting. War-time demands have created a very real problem everywhere we turned. The hotel situation has been critical from the very beginning. The difficulties that have been in the way of getting historical exhibits together have been numerous and everything that we have wanted to do in the way of entertainment has been much more expensive than usual. These chairmen and their committees have tackled all of these difficulties and have not been overwhelmed by any of them and the success of the meeting will be in no small measure the result of their untiring efforts.

The two committees that have had the largest tasks to carry out have been the Committee on Exhibits and the Committee on Hotels. Dr. Bookhammer has arranged a really noteworthy exhibit of the historical material relating to the history of the Association and a great deal of this material can become a part of a permanent record. The gathering of this material has required a great deal of time-consuming research work, a good deal of correspondence and the result, as you will see, justifies all the time and effort that has gone into it. Dr. Bookhammer has given unsparingly of his time and deserves the appreciation of the Association for the job that he has fulfilled. He has had a good deal of help from Dr. Gregory Zilboorg who in his capacity as chairman of the committee on the history of psychiatry has given

\* Now serving in army.

invaluable help and has made available a great deal of material for the exhibit. I feel certain the Association will be very proud of this exhibit.

The sub-committee on hotels has had a most trying job. We have not been sure from day to day just where we have stood on the matter of hotel space and at the time of writing this report we are in a real dilemma as to whether or not we can provide enough space for the attending members and guests. The managers of the local hotels have been most cooperative. They have been faced with a situation beyond their own control. We have all recognized that the demands of the military do come first and we have accepted the shifts and limitations imposed upon us with a feeling that somehow or other we will see it through. We do hope that we have the sympathy of the attending members and the willingness to put up with some of the inconveniences which are the necessity of being in hotels somewhat distant from headquarters, and the necessity of doubling up, etc. The women's committee has assisted with the appointment of a housing committee and I anticipate that will be of great help in arranging for living quarters outside of hotels, particularly for those who need reservations at the last. Everybody has been willing to make some sacrifices on this and are determined that everyone who comes to the meeting shall have some place to stay. Dr. Maeder deserves a great deal of credit for the time he has put in on this committee.

The sub-committee on publicity under the chairmanship of Dr. Robert A. Matthews is now beginning to get into action. We felt that publicity in the last few weeks was much more important than earlier publicity. The newspapers have indicated their interest in helping us, but in view of the shortage of news space they have wanted news material and have suggested that we concentrate our publicity efforts in the days just preceding the meeting.

The Committee on Entertainment has arranged a very interesting program for the attending members and the guests. The party on Tuesday evening following the round-table will be a very informal type of get together in which members can relax a little and enjoy just getting together. We are arranging to entertain the members and their guests at a cocktail party preceding the banquet. Here again we have been faced with certain restrictions necessitated by war-time conditions and will not be able to give the usual type of drinks. However, we are hoping that every one will enjoy the hospitality that we are so anxious to offer and will enter into the spirit of the occasion. The program for the banquet itself has been largely in the hands of Mr. Davies and it promises to be a most unusual affair.

The Finance Committee, headed by Dr. Palmer, has been able to carry out its assignment to raise the funds for our local budget because of the great interest that exists throughout the states of Pennsylvania, New Jersey and Delaware. Dr. Palmer's committee which has been the largest of the sub-committees has tackled this job with great enthusiasm and as a result, long before the

meeting, ample funds have been subscribed to take care of our local needs.

Mrs. Madeline Appel has organized a very active women's committee and is working in close collaboration with the general committee who are arranging for an interesting program for the women guests, which has, as its major event, the tea at the Art Museum on Tuesday afternoon. The women who will be attending the meeting will be assured of a very interesting time. This year the women's committee has done more than arrange for the women's entertainment, and are giving invaluable help to the general committee, particularly on the housing situation.

In all of our work we have had the constant help and advice of Mr. Austin M. Davies. He has been willing to come to Philadelphia whenever we have needed him and when we have run into certain snags he has been most helpful in working through them. I want to express my own and the appreciation of the entire Arrangements Committee for the skillful cooperation we have had from him.

FREDERICK H. ALLEN, M. D., *Chairman.*

#### REPORT OF THE COMMITTEE ON NOMENCLATURE AND STATISTICS

During the year past, the publication of the annual statistics on Mental Disease, Mental Deficiency, and Epilepsy was removed from the Division of Vital Statistics, Bureau of the Census under Dr. Halbert H. Dunn, and placed under the jurisdiction of the Division on Population, Bureau of the Census, under Dr. Leon E. Truesdell. The 1940 edition of "Patients in Mental Institutions" is the last volume published but work on the 1941 and 1942 editions is under way. I am told by Mr. J. C. Capt, Director, Bureau of the Census, that analysis of the country-wide material of the 1941 and 1942 reports shows little change from the figures presented in the 1940 report. This volume is in three sections and reports on Mental Deficiency and Epilepsy, as well as Mental Disease.

Last year, your committee suggested that the 1943 Decennial Census on the resident population of mental hospitals, state schools for mental deficiency, and hospitals for epileptics, be postponed until 1944. Continuation of the war and the attendant shortages of clerical forces render necessary a further postponement as the detail of the work in reporting several different items on each resident patient, would be difficult if not insurmountable. It has been suggested to the Bureau therefore that the detailed analysis of resident population be postponed until such time as the institution shall have sufficient physicians and clerical workers to carry out this work in a satisfactory manner.

It is urged, however, that institutions make every effort to keep up record work and to preserve their statistics in as careful a manner as possible during the war years. It is always difficult to go back and to bring up-to-date records on which critical information is lacking.

The next edition of the Standard Nomenclature

of Disease is scheduled for 1947. It is highly desirable that all suggested changes of the psychiatric nomenclature (Mental diseases, pages 100-107; Mental deficiency, pages 97-98; and Convulsive disorders, pages 524-526), be forwarded to the Chairman of your Committee as early as possible. In this way, there will be ample time for their consideration and presentation to the Council for approval. If administrators will make a point of bringing up this question before their Medical staffs now and stimulating action in this direction, the need for hurried action later will be obviated.

Respectfully submitted,

NEIL A. DAYTON, *Chairman*,  
CLARENCE O. CHENEY,  
GEORGE F. BREWSTER,  
GEORGE S. SPRAGUE,  
J. P. S. CATHCARTS,  
ABRAM E. BENNETT,  
HUGH CARTER HENRY,  
GROVER A. KEMPF,  
JAMES V. MAY,  
JACOB KASSANIN.

#### REPORT OF THE COMMITTEE ON PSYCHIATRIC STANDARDS AND POLICIES

Your Committee on Psychiatric Standards and Policies considered and discussed the following questions:

1. What can we do to establish public trust and confidence of the medical profession?
2. How to improve the care of mentally ill in state and private hospitals?
3. How to retain the services of more skilled psychiatrists in the clinical field?
4. How to create a basic guide for instruction of medical staff members?
5. How to utilize the enormous clinical records for research?
6. Is it advisable for The American Psychiatric Association to establish headquarters in its own building with adequate library, research and information bureaus?
7. Should The American Psychiatric Association play a similar rôle as The American College of Surgeons and other highly specialized branches of medicines?
8. Should The American Psychiatric Association assume more responsibilities and consider the National Committee for Mental Hygiene, Inc., an educational and pre-preventive organization, with whom it should have better co-operation?

It is the opinion of the committee that the original report issued in 1925 and amended and re-issued in 1941 is to be considered as the minimum objective of the average psychiatric hospital. However, neither the original report, nor the amended one did mention the standards and policies of our Society, in regard to psychiatry as a whole.

Our Association will have a great opportunity in the post-war period to wage a total war against the early twentieth century methods of the care

and treatment of the mentally ill, also to change the concept of the people in regard to psychiatrists as well as psychiatric hospitals.

The policy of our Association should be based on the same principles as the policies of similar specialized branches of medicine, such as The College of Surgeons. To achieve such recognition The American Psychiatric Association should broaden its scope on Standards and Policies and make these available to the medical profession, the public, the political subdivisions of the state and others as they may be called for.

The time has come when our Association should be prepared to assume its well deserved place. This can be achieved only through the creation of public trust, by means of *adequate education, service and further research work.*

The American Psychiatric Association has done very little in regard to public education, most of the work being carried on by The National Committee for Mental Hygiene, Inc.

The educational phase must be divided into two definite plans; namely, better training in medical schools, by encouraging the students to become more interested in psychiatry, and adequate training of younger members of the hospital staff. For improving the standards of care and treatment, our committee might record its endorsement of the post-graduate institutes held from time to time in different parts of the country under the auspices of the Committee on Psychiatric Education. The training that is given to physicians in most of our institutions is quite desultory. They enter the institution as junior members of the staff, meet an almost overwhelming case-load, learn as much as they can from their work, but have no time for any systematic instruction. This project is under the jurisdiction of the Committee on Psychiatric Education. It is recommended that the Committee on Standards and Policies and the Committee on Psychiatric Education set up a basic guide for instruction of the new medical staff members in psychiatric hospitals. The second plan should be based on the general education of the public.

Adequate psychiatric service has not been available to *the mass of our population.* It is very common not to find a psychiatrist within a radius of over one hundred miles. Most of the psychiatrists are located in large cities and in mental hospitals.

Psychiatric service rendered by hospitals and clinics has never been on the same basis as the services of other branches of medicine in general hospitals. Complete reorganization of hospital service should be recognized as being necessary by our Association. A uniform requisite for admission should be considered as vital. Outside of a few, the majority of cases should be considered on a voluntary admission basis. Through education such a procedure will become the rule rather than the exception.

State hospitals for mentally ill should be so well planned that the public will accept them on the same basis as schools. Such service can be rendered to the people only through a competent staff.

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In the past the difficulty of retaining skilled psychiatrists in the clinical field is partly one of finding institutional openings where they can feel that there is some opportunity for professional growth. So long as the skilled psychiatrist is placed on a par with his older brother who is merely a "state hospital doctor" with no real interest in psychiatry, he will become discouraged with his professional work and look for other openings.

A true medical and psychiatric service can be rendered to the patients of our hospitals through competent personnel which cannot be obtained in any state without consideration of salaries and wages of such a personnel.

The society should be concerned especially about the standards related to clinical activities. In the majority of our hospitals the most skillful psychiatrists are relegated to administrative responsibilities, while the person-to-person treatment of our patients is delegated to the youngest and most inexperienced staff members.

Related to the matter of research is the whole system and practice of clinical records. Much valuable material that goes into case records is merely filed away and never used for research purposes. The system and practice of clinical case records should be reviewed, and the system should be set up with an eye to the research value of these records. The tendency in many hospitals is to leave the matter of research up to certain selected staff members, rather than to encourage an attitude of research and research activities among the entire group. There is too much "blind" research work done today. There are too many correlations attempted without any basic association of the factors involved. Perhaps a central guiding research committee could be available to assist and encourage certain positive approaches to certain diseases.

The making of psychiatric records presents serious problems which have certainly never been completely solved. While too much standardization is not desirable, it might just be that if the proper committee or subcommittee were named, such committee might outline some of the fundamental and indispensable qualities of satisfactory case records, such as steps to insure accuracy and reliability of data, avoidance of ambiguous and vague terminology, insuring precise meanings of technical terms, attempting to distinguish relevant from irrelevant material, etc.

The committee feels that The American Psychiatric Association should be organized on such a basis that the service will radiate from its Central Headquarters to the whole of the United States of America as well as Canada and other countries of our Hemisphere. It has been proposed by our former presidents as well as some of our committees that The American Psychiatric Association should have a centrally located building, preferably in New York City. This center should have a complete library as well as a research laboratory with well qualified personnel. It is also the opinion of our committee that this

center should be directed by a well qualified psychiatrist.

This center should also have supervisory power over research work in other hospitals.

Our organization with over 3000 members should be able to maintain such headquarters. The committee feels also that the National Committee for Mental Hygiene, Inc. should be housed in the same building and that there should be a much closer relationship between the two.

In conclusion your committee suggests that the Council authorizes the committee, with the assistance of all other standing committees of the Association, to prepare the necessary "Standards and Policies" incorporating the above recommendations and submit the same to our centennial meeting in May, 1944.

Respectfully submitted,

M. A. TARUMIANZ, *Chairman*,  
GILBERT J. RICH,  
J. FREMONT BATEMAN,  
HARRY J. WORTHING,  
FREDERICK LEDREW,  
CLARENCE B. FARRAR,  
WILLIAM D. PARTLOW,  
LETCHER E. TRENT,  
HOWARD W. POTTER,  
KENNETH J. TILLOTSON.

#### REPORT OF THE COMMITTEE ON NURSING

In reporting in December, 1943, the work of this committee was outlined. The need and reasons for graduate courses in psychiatric nursing at the university level and for which degree credits would be given were pointed out. Your committee is pleased to report progress in this type of training. Four universities are either giving courses of this type or have plans completed to give graduate courses in psychiatric nursing beginning in September, 1944. A committee of the National League of Nursing Education has drafted an outline of the desired content and objectives of this type of course. Your committee approves of the outline and has made only a few suggestions for amendments and additions.

The work on a manual and guide for the training of attendants has gone forward. The content has been determined with the help of committee members. The practicability of the course is being tested and the results have been favorable. The Rockefeller Foundation has been approached with respect to financing publication and distribution. Dr. Alan Gregg has expressed willingness to support a special request up to \$1700 to defray these costs. Mrs. Fitzsimmons has done the work on the manual. A request for a grant of funds in this amount should be submitted through Dr. Gregg to the Trustees of the Foundation in December, 1944. At the same time a request should be made for further funds to carry on the work of the nursing project for an additional three to five years. The present grant expires July 1, 1945. Your committee believes that a point has now been reached which marks the turning of the corner so far as dividends are concerned. On the basis of

data now assembled, constructive planning is possible to meet the needs of the future in training psychiatric nursing personnel and attendants. We now know where we can go and the ways and means to get there. We did not know this nor would we be likely to know it without the opportunity which was afforded by the Rockefeller grant of funds to compile data.

Your chairman since December was invited to write for the *American Journal of Nursing* an article on "A Guidance Program for Student Nurses." This will appear in the Journal soon. He has also had an opportunity for working on the general nursing situation in Southern California and suggesting principles for the development of psychiatric nursing programs in that area. Drs. Glenn E. Myers and Walter L. Treadway deserve commendation for their missionary work in psychiatry and psychiatric nursing in Los Angeles. A definite program to encourage institutions giving courses in psychiatric nursing to seek accreditation has been postponed temporarily until an opportunity could be given for consideration by the committee. There are reasons for going ahead with such a program and also reasons for delay until conditions become more stable. The matter will be discussed by the committee at Philadelphia.

Your committee believes that Council should support a request for a further grant of funds from the Rockefeller Foundation to continue the nursing project for at least three years after July 1, 1945, when the present grant expires.

Your Chairman should be empowered to continue and conclude negotiations with the Foundation on the same basis as has prevailed previously.

Your committee desires to commend its nursing consultant, Mrs. Laura W. Fitzsimmons. On her has fallen the bulk of the work and from her has come much constructive thinking and action. Your Chairman is appreciative and thankful for the advice and constructive suggestions of the committee members and the Advisory Committee. Without their support and encouragement the present status would not have been achieved. He believes that general nursing education is now beginning to be influenced by the thinking of the Committee on Nursing and that the status of psychiatric nursing in the undergraduate curriculum and in graduate courses has been clarified and goals crystallized. He has a feeling of optimism about the future influence of the committee in the field of nursing education, including guidance programs and ancillary byways of education in psychiatry.

Without indulging in too much phantasy your committee believes that it is exerting a positive influence for advancement in the whole field of nursing education and is in a position to play an authoritative and advisory part in developing psychiatric training programs. The committee believes that it can stimulate, encourage, and advise positively about training and general policies in psychiatric nursing and the training of psychiatric attendants. The approval of the Association for nursing courses and attendants' training should be

a necessary aim for institutions giving training to these groups.

CHARLES P. FITZPATRICK, M. D.,  
Chairman,  
JAMES H. WALL, M. D.,  
KENNETH E. APPEL, M. D.,  
ARCHIBALD McCausland, M. D.,  
WILLIAM L. PATTERSON, M. D.,  
HENRY I. KLOPF, M. D.,  
RALPH M. CHAMBERS, M. D.,  
MARCUS A. CURRY, M. D.,  
GEORGE S. JOHNSON, M. D.

#### REPORT OF THE COMMITTEE ON PSYCHIATRIC SOCIAL SERVICE

During the past year, there has continued the close collaboration between this committee and the Committee of the American Association of Psychiatric Social Workers.

##### A. MILITARY SOCIAL WORK

Because of the exigencies of the war, special emphasis has been placed upon our efforts to extend military social work in the armed services. The success of these efforts is largely due to the active collaboration of Mrs. Elizabeth Ross, the Secretary of the War Service Office of the American Association of Psychiatric Social Workers, in conjunction with the fine support of Dr. Edward Strecker, President of the American Psychiatric Association. Dr. George Stevenson of the National Committee for Mental Hygiene, and Miss Marian McBee, Executive Secretary of the New York City Committee for Mental Hygiene.

On June 25, 1943, at the invitation of Mr. Eugene Meyer, Publisher of the Washington Post, a luncheon conference was held with Assistant Secretary of War McCloy, Colonel R. Halloran, Dr. Edward Strecker, Dr. George Stevenson, Miss McBee and the Chairman of this Committee. Exploration of the subject for extension of the use of psychiatric social workers, now members of the armed forces, resulted in an arranged conference with the Surgeon General Kirk on June 26, 1943.

The late Colonel Halloran, Miss McBee and the Chairman, discussed the specifications of a classification subsequently known as 263. In October, SSN 263 was established.

##### B. CRITERIA FOR EVALUATION OF TRAINING AND WORK EXPERIENCE

During the early summer, the War Secretary of the Association of Psychiatric Social Workers and the Chairman of The American Psychiatric Association's Committee on Social Service formulated criteria for evaluation of training and work experience of graduates from schools of social work, so that Army Psychiatrists, privileged to work in psychiatric units could readily identify the training and experience background of military social workers available in their respective service commands.

## C. AIR FORCE

During the past year, through the active support of Lt. Colonel John Murray of the Air Service, psychiatric units in the Air Force in this country have been permitted to utilize Military Social Workers in increasing numbers.

## D. MENTAL HYGIENE UNITS

The first Mental Hygiene Unit established in the Army, mentioned in last year's Committee Report as functioning at Fort Monmouth, was transferred to England General Hospital at Atlantic City. This unit, since its inception at Fort Monmouth, has utilized the services of Military Social Workers. In their present assignment, these men are engaged in carrying a very real part of the case load both on an individual and group therapy basis in the reconditioning of psychiatric casualties.

During the past year, there has been an extension of the number of psychiatric units using Military Social Workers mainly in Replacement Training Centers, in Station and General Hospitals and in Prison Rehabilitation Centers.

In addition, there is recent word of further psychiatric services utilizing psychiatric social workers in Reconditioning Facilities and in relation to the reclassification of former Neuro-Psychiatric patients.

Thus far, the use of the Military Social Workers with Division Psychiatrists has not developed far enough to merit special mention.

With the present shortage of psychiatric personnel in the Medical Corps of the Army, it is to be hoped that most of the three hundred men highly trained in the profession of psychiatric social work and the unknown number of hundreds of men eligible under the experience requirements established by SSN 263, and who are at present assigned to tasks other than psychiatric in the Army, may soon be utilized through their specification classification for extending Mental Hygiene Unit Work as Military Case Work Assistants to psychiatrists.

## E. THE WAC PROGRAM

In the fall of 1943, an outstanding psychiatric social worker, Mrs. Elizabeth M. deSchweinitz, was appointed as Civilian Consultant to the Director of the WAC.

In November, plans were developed for the psychiatric screening of applicants for enlistment.

The organization of a screening process now in an experimental stage, which permits the gathering of adequate social histories and the making of effective psychiatric examinations of candidates for enlistment, represents another step forward in a more effective social psychiatric program.

During November, the War Service Office of the American Association of Psychiatric Social Workers sent a letter of inquiry to all graduate schools of social work. A request was made for information regarding former women graduates enlisted in WAC Service who had fulfilled the training and experience requirements for the Civil-

ian Social Work Classification 263 issued in October, 1943 for men Military Social Workers.

## F. SSN 263 QUALIFICATIONS

The final qualifications for SSN 263 in the army are "at least two years of supervised experience in a public or private agency." (Social Case Work) or "graduate work with a degree in Social Work granted by a recognized school of social work."

This effort on the part of the War Service Office was made in order to assist in furnishing the Women's Army Corps Office with pertinent data regarding women with qualified training, who might be available for assignment to work with psychiatrists.

It is important for this Committee and the Association of Psychiatric Social Workers to continuously uphold the high standards of training preparation required for psychiatric social work personnel.

In the past ten years, a high level standard of professional training has been established thru the efforts of the Committee on Psychiatric Social Work of the A.P.A., and the Committee on Professional Education of the American Association of Psychiatric Social Workers.

## G. DIRECTIVE FR 200

In the light of these established standards, attention should be paid to a Directive FR 200 of March 24, 1944 relating to Procurement of Female Technicians for Medical Installations.

The requirements as stated in this Directive calls for—

- (a) "Two years of Social Work" (no qualifications regarding the type of agency or supervision are stated).
- (b) or, "graduation from college with a major in psychology and sociology,"
- (c) or, "two years of college with some work in psychology or sociology."

The Procurement Officers are instructed that following the completion of Basic Training there will be a guaranteed placement in a psychiatric unit.

This directive indicates a very serious lowering of standards both for training and experience. With such inadequate preparation and incomplete equipment, effective Military Case Work in the best psychiatric social work tradition cannot be done. The large number of neuro-psychiatric casualties developing in the armed services indicates the necessity for doing effective Military Social Work for these men with the intent to return as many men to military service as can be properly adjudged cured thru adequate use of psychotherapeutic methods in the Army psychiatric services.

## H. ADVISORY COMMITTEE TO THE RED CROSS

Mrs. Maida Solomon, Chairman of the Advisory Committee to the Red Cross of the A.A.P.S.W. in

conjunction with the able leadership of Dr. George Stevenson, Director of the National Committee for Mental Hygiene, has rendered real assistance during the war period thru aiding in recruiting for psychiatric social work jobs, assisting in establishing standards of hospital personnel selection, collaborating in plans for scholarship programs in service training and job supervision.

#### I. MEDICAL FIELD AGENTS

Throughout the war period, civilian social workers with psychiatric training and orientation have volunteered their services to obtain histories to be used in the psychiatric screening process at the induction centers.

Dr. Luther Woodward, a psychiatric social worker, was made available to Selective Service Headquarters in Washington through the auspices of the National Committee for Mental Hygiene.

Through his efforts in many states, more effective collaboration of social workers with Local Boards and State Selective Service Headquarters was made possible.

On October 18, 1943, Medical Circular No. 4 was released by the Office of Emergency Management, War Man Power Commission Selective Service System.

In this circular through amendment, there was established a category of Medical Field Agent. Through this action, volunteer social workers now become specifically directed agents to the Local Boards.

#### J. REQUIREMENT STANDARDS

The requirements for education and training created constitute a recognition of social work as an accepted profession.

As of May 1, 1944, there are 8000 social and health workers volunteering their services as medical field agents to Local Boards throughout the country. Forty states have established Advisory Committees appointed by the State Directors of Selective Service.

Plans are now under way to submit to Congress a request for minimum funds required by cities and states to facilitate the mechanics of obtaining record material.

After the war, when figures are made available, it is safe to conclude that there will be many real evidences of more effective psychiatric screening processes by Induction Centers because of the work done by these Medical Field Agents.

#### K. JOINT MEETING OF APA COMMITTEE AND AAPSW

During the year there was one joint meeting at which four important reports were made to the APA group and other interested psychiatrists.

#### L. SELECTIVE SERVICE—CASE WORK PROGRAM IN NEW YORK CITY

Mrs. Ethel Ginsburg, a psychiatric case worker, whose services were supplied to Selective Service

Headquarters by funds made available through the efforts of the New York City Committee of Mental Hygiene, gave a very complete picture of the intensive and extensive efforts to recruit volunteer social workers for work with Local Boards. In order to maintain standards of work the local chapter of the AAPSW had accepted the responsibility for organizing and sponsoring an "in-service" training program for Medical Field Agents. To further extend the efficacy of the Medical Field Agents function a discussion group was planned under the sponsorship of the Executive Secretaries of the regional councils of the Welfare Council and a tentative plan was in progress of development for consultations to be made available for workers relating to individual problems.

Since this report, the work has continued to expand and at the time of this report, there are over six hundred volunteer Medical Field Agents functioning with the 280 Local Boards in New York City.

#### M. REPORT OF STUDY OF REHABILITATION AND PSYCHIATRIC NEEDS OF DISCHARGED AND REJECTED MEN

Marian McBee, an outstanding psychiatric social worker, who serves as Executive Secretary of the New York City Committee of Mental Hygiene gave a very complete outline of the work of her Committee. Some evidence of the size of the neuro-psychiatric problem among rejectees in New York City area alone can be gleaned from the fact that by September, 1943, it was estimated there would be over 90,000 men rejected from military service for neuro-psychiatric disabilities and the number of neuro-psychiatric discharges from the Army to this area would probably be 15,000 to 25,000 for the same period.

Because clinical services have never been adequate in peace time a special Committee on Rehabilitation was created under the Chairmanship of Dr. Lawson Lowrey.

Dr. Lowrey outlined the essential problems for study by his committee as follows:

1. How many individuals will need some kind of rehabilitation program?
2. The need to ascertain the types of disabilities for which men are discharged.
3. What kind of rehabilitation program is needed?
4. A need to determine what facilities are now available and what further facilities need to be developed.
5. How many of these men are already known to other agencies and how many of them have had service of some kind.

Dr. Lowrey reported the projected committee program for the study of 500 cases of rejectees and 500 discharges as a sampling in an effort to some pertinent information needed to answer the questions stated above.

Mrs. Elizabeth Ross furnished the group with a very complete survey of the manifold functions of

the War Service Office and made it possible for the joint committees to discuss in great detail, opportunities for future more effective collaboration.

#### N. REPRINT SERVICE TO PSYCHIATRIC SOCIAL WORKERS IN SERVICE

During the year, through the generosity of the Josiah Macy Jr., Foundation and its Director, Dr. Frank Freemont-Smith, reprints of psychiatric war material published in professional journals, have been sent to many of the psychiatric social workers in the armed services. This has been made possible through the joint efforts of the War Secretary of the AAPSW and Dr. George Stevenson of the National Committee for Mental Hygiene. In this way the many men trained in psychiatric social work but assigned to military duties other than Military Social Work, are permitted to keep alive their interest and knowledge of current psychiatric trends in the armed services.

#### O. VETERANS BUREAU PROGRAM

A short time ago, through the auspices of the Psychiatric Social Worker in the Administrative Division of the Veterans Administration in Washington, a recommendation was made which, if acted upon favorably, will permit higher standards of training for personnel and a salary scale range for psychiatric social workers which will be comparable to the standards now in operation in the best public and private agencies in the country. This program deserves a great deal of support for if such a plan is put into operation, it will enlarge the opportunity for recruiting well trained and well qualified psychiatric workers in the social service work of the Veterans Hospitals.

#### P. PROJECTS FOR COMMITTEE WORK NEXT YEAR

Real effort should be made to further organize plans for adequate Rehabilitation Services for rejected and discharged men from the armed services.

It is proposed that the joint Committees of the APA, Psychiatric Social Service and the AAPSW shall have bi-monthly meetings to extend the collaborative efforts of the past years.

Respectfully submitted

MARION E. KENWORTHY, M. D., *Chairman*,  
 RUSSELL E. BLAISDELL, M. D.,  
 HELEN P. LANGNER, M. D.,  
 ESTHER L. RICHARDS, M. D.,  
 HARRY C. SOLOMON, M. D.

#### REPORT OF SPECIAL COMMITTEE ON PSYCHIATRY IN THE ARMED FORCES

Since the last meeting your Special Committee on Psychiatry in the Armed Forces has held two meetings and had frequent telephone and letter communications.

On February 9, 1944, Dr. Strecker and Dr. Parsons met with Colonel Menninger in the office of the Surgeon-General in Washington, and discussed

the matter of training of younger psychiatrists and the development of a number of courses in connection with medical schools in New York. The committee approved of this plan of the Consultant to the Division of Neuropsychiatry in the Surgeon-General's office, and as many of you know that plan has been put into operation.

On April 7, 1944, your committee met with Colonel William C. Menninger and the members of his staff in the Division of Neuropsychiatry in the office of the Surgeon General.

After the appointment of Colonel Menninger as consultant to the Division of Neuropsychiatry, the Secretary of War had officially appointed the members of the Special Committee on Psychiatry in the Armed Forces as Consultants to the Division of Neuropsychiatry in the Office of the Surgeon-General; thus, we were given official status.

The members of your committee were delighted at the time of the meeting on April 7 to find that Lt. Colonel William C. Menninger had on that day been promoted to a full Colonelcy, a well deserved recognition of his leadership.

The various members of Colonel Menninger's staff reported to the Special Committee on Psychiatry in the Armed Forces on the present status of the hospitalization plan which appeared to be progressing satisfactorily.

The treatment directive, Technical Bulletin No. 28, was explained and was endorsed by the committee.

The organization curriculum of the school for neuropsychiatry at Columbia University and Bellevue Medical School was presented and explained. These schools, in addition to the course given at Mason General Hospital, are providing a three month's training in psychiatry for 140 medical officers.

A plan for the utilization of psychologists and psychiatric social workers under the direction of psychiatrists was presented.

The development of neurology, and particularly the neurosurgical and neurological centers which are under consideration, was explained.

The work and publication of the Mental Hygiene Branch of the Neuropsychiatric Division was presented and numerous copies of the printed text were studied and approved.

Other matters discussed were the replacement training center experimental units, and the committee felt that this program should be continued and further developed.

The Director of the Division, Colonel Menninger, related tentative plans on nomenclature of psychiatric disorders, explaining that these plans had been sent to numerous civilian and military psychiatrists for their suggestions, with the hope of clarifying the present rather complicated and confusing situation regarding nomenclature.

The Director reported that he had been in correspondence with the Chairman of the American Psychiatric War Committee, Dr. Harry Steckel, and had suggested to Dr. Steckel's committee a number of ways in which that committee could be extremely useful in the war effort. Among these

suggestions were attempts to enlist more psychiatrists for the armed forces, the enlistment of civilian psychiatrists to aid in induction centers, the rehabilitation of discharged neuropsychiatric patients, and the consideration of post-war training for psychiatrists.

One of the staff members gave a résumé of a recent inspection trip in two of the Service Commands of this country, and your committee felt that definite progress had been made in the induction procedure, in treatment in hospitals, and in effecting more prompt discharge in the case of NP disabilities that would not benefit sufficiently to enable them to remain in the armed forces.

The medical survey program in Selective Service was considered, Medical Circular No. 4 was discussed, and the committee expressed itself as desirous of seeing that instructions of that circular were carried out as carefully as possible, in order that its effectiveness in the induction centers should be made as complete as time and personnel will permit.

Dr. Strecker reported briefly on an official inspection trip he had recently made in England, and commented most favorably on the care of the neuropsychiatric cases in the many hospitals he visited.

Your committee hopes to have frequent meetings with the Director and staff of the Neuropsychiatric Division of the office of the Surgeon-General, and is appreciative of their desire to have The American Psychiatric Association informed of what is going on as far as military restrictions will permit. The Committee is very appreciative of the active interest and help proffered by Major General Norman T. Kirk, Surgeon General of the Army.

Respectfully submitted,

ARTHUR H. RUGGLES, M. D., *Chairman,*

EDWARD A. STRECKER, M. D.,

FREDERICK W. PARSONS, M. D.

#### REPORT OF COMMITTEE ON PSYCHIATRY IN MEDICAL EDUCATION

Your Committee on Psychiatry in Medical Education wishes to submit the following report of activities for the consideration of council.

1. The neuropsychiatric slide collection has continued in general use during the past year. *An atlas, including microphotographs, is now ready for distribution.* This atlas will be available at a nominal cost to all members of our Association and will prove of great value in the interpretation of each of the hundred slides in the collection. February 27, 1944, Colonel J. E. Ash, Curator of the Army Medical Museum, in the enclosed letter to the secretary of our Association suggested that The American Psychiatric Association appoint a committee to cooperate with similar committees appointed by the American Neurological Association and the American Society of Neuropathologists, and announced the establishment of a registry of neuropathology at the Army Medical Museum similar to the registries already in operation in other fields. Such a registry is different from the loan collection now used for teaching purposes

in that neuropathological specimens are submitted to a number of experts in this field in an effort to bring additional precision to neuropathological diagnoses. Your committee suggests that, since there are several outstanding neuropathological members of our Association, we should facilitate in every way possible this final organization of a central registry in neuropathology, that such a committee should be appointed, and that careful consideration should be given to each of the eight points brought up by Colonel Ash.

2. The various members of the committee have discussed, through correspondence, the importance of developing brief psychiatric instruction for all Army medical officers entering the service. There is unanimous agreement that sufficient instruction cannot be offered in a brief indoctrination course to give any depth of understanding, since officers entering the service will vary enormously according to the instruction they have received as well as in their personal aptitudes. The committee, however, advises that further attention should be directed specifically to the prevalence of the psychoneuroses and psychosomatic disorders. Such an indoctrination course should be aimed toward helping the medical officer deal with the emotional and personal features of a soldier's illness and based on an understanding of the effects of physiological disturbances of emotional origin, especially as expressed in psychosomatic disorders.

3. In many medical centers courses in military psychiatry have been developed as a part of the general instruction in psychiatry. The interest and enthusiasm regarding psychiatry as a basic phase of the general medical training has continued. Also, postgraduate courses have rapidly developed to meet military needs both for the Army and Navy. This work is especially well developed by special courses in Philadelphia for the Navy and at St. Elizabeths Hospital and elsewhere. The course of instruction at the School of Military Neuropsychiatry (Army) has been extended to a three-month period, and the facilities of several medical schools are being further utilized for such instruction. The War-Time Graduate Medical Meetings have also done commendable work, which again has served to cement internal medicine and psychiatry closer together. In addition, the Eighth Service Command has arranged for visiting teachers and has distributed monthly psychiatric case histories to be used as a basis for discussion in the various fixed hospital units.

4. The excellent film, "Psychiatry in Action," prepared under the direction of Dr. Walter S. Maclay, Director of the Mill Hill Emergency Hospital, London, England, has proved to be of great educational value wherever presented during the past year. Your committee recommends that The American Psychiatric Association inaugurate steps for the production of a similar type of educational film in the near future. This should not be an extremely difficult undertaking, since there are many psychiatric centers in this country where such a film could be produced under careful supervision.

5. There is a growing understanding of the great importance of the psychosomatic aspects of medicine which gives evidence of becoming one of the outstanding medical developments in the present conflict. What is more important, psychiatry is now accepted as a fundamental part of the general medical team and it can be anticipated that medical schools will improve and augment their curricula to better meet these needs. We have great opportunities in the future, therefore, for making continued clinical and educational progress as an integral part of general medicine and surgery rather than, as heretofore, a detached specialty.

6. In summary, therefore, your Committee on Psychiatry in Medical Education suggests to Council that definitive action be taken on each of the eight points presented by Colonel Ash of the Army Medical Museum.

Your committee likewise suggests that The American Psychiatric Association take under advisement, in collaboration with the Committees on Public Education and Psychiatric Standards and Policies, preparation of a carefully edited psychiatric film demonstrating the successful application of various types of therapy now in use in mental hospitals.

FRANKLIN G. EBAUGH, *Chairman*,  
JOHN ROMANO,  
JOHN C. WHITEHORN,  
BALDWIN KEYES,  
WILLIAM C. PORTER.

#### REPORT OF THE COMMITTEE ON WAR PSYCHIATRY

No formal meetings of the committee have been held but correspondence has been had with the members from time to time.

Our committee has continued to distribute the organizational outlines for civilian mental health compiled by the committee last year, together with previously compiled material on Morale, Anxiety, and so forth, all of which has had nationwide distribution.

The Subcommittee on Clinical Psychiatry, following a highly successful round-table discussion on Industrial Mental Health which was held during the Detroit meeting, undertook to foster this field as its major activity. However, owing to the chairman of the subcommittee moving to Montreal and, therefore, not being in the central position to push developmental work, a new Subcommittee on Industrial Mental Health was organized under the chairmanship of Dr. Frank Tallman who has had some experience in this work in the state of Michigan. More recent activities of this subcommittee have been directed toward defining those trends in psychiatry which have either originated during the war or have been fostered as a result of the war and which seem likely to be transferred over into civilian work. Particular attention has been directed to three major trends: (1) selection as a preventive measure; (2) emergency psychiatry; and (3) group psychotherapy. The possibility that these three trends might contribute extensively to post-war civilian psychiatry has been discussed in detail and a round-table has

been planned to give further emphasis to these trends at the coming meeting in Philadelphia.

The Subcommittee on Industrial Mental Health has made a comprehensive report of the deliberations of that subcommittee in which they outline the need for the introduction of psychiatric techniques into industry, outlining also the opportunity which is afforded psychiatry in this respect and mentioning especially the application of psychiatry and mental hygiene in employment, job training, safety, medical department, and the personnel situation, with special reference to absenteeism, employee complaints, employee discipline and foremanship. In a general way this subcommittee suggests the following definite and planned action:

- (1) All psychiatric and mental hygiene societies, but specifically The American Psychiatric Association, should encourage the inclusion on national, state and local psychiatric programs, subjects relating to this problem. These expressions may take the form of papers, panels, round-tables, etc.
- (2) The American Psychiatric Association should have available copies of plans and programs found useful in industry for any members who request them.
- (3) The members of The American Psychiatric Association should hold themselves in readiness to appear on programs of other national, state, and local organizations of a different discipline in order to express their viewpoints. Examples of such organizations are the National Safety Council, and the American Association of Industrial Physicians and Surgeons, etc.
- (4) It should be kept in mind that industry's first interest is in problems of plant personnel. They have a secondary and rather minor interest in diagnosis and treatment. A number of industries will welcome psychiatric attitudes and techniques in the general operations of their plant, but would not, under any consideration, set up a psychiatric clinic.
- (5) Mental health material should be provided for publication in trade journals, safety publications, etc.

It would almost seem to us that with such an elaborate program suggested by this subcommittee, there might better be a special Committee on Industrial Activities appointed, taking it out of the province of the Committee on War Psychiatry as this activity would undoubtedly carry over into the post-war period.

A number of suggestions with reference to activities which this committee might undertake have come to us from members of Council and members of the Association in general. One of these had to do with the matter of medical histories for Selective Service. The committee feels this is covered by Medical Circular No. 4, dated October 18, 1943, and while some areas lack social service personnel so that a perfect job is not being done in all areas, further action by this committee does not seem essential or feasible at this

time, except perhaps to urge all civilian psychiatrists to lend their services to this activity to the fullest extent possible.

Our committee has offered its services to Colonel Menninger of the Surgeon General's Office, to be utilized in any way he might see fit so far as its limited resources permit. He has outlined several projects in which the committee might be helpful, some of which our committee feels unable to undertake because of lack of facilities, while others were being handled by other groups. For instance, the Josiah Macy Jr. Foundation has undertaken the reprinting and distribution of recent contributions on the subject of war psychiatry. This material is going out to all psychiatrists in both the Army and Navy.

Colonel Menninger is quite anxious to secure the services of additional psychiatrists for the military forces. No doubt there is a real need for such officers but this committee does not see how it is in a position to make the necessary contacts in order to interest men in joining the armed forces. The question has been raised as to whether all medical officers trained in psychiatry are being utilized for that specialty in the Army.

It seems to this committee that the only way to secure additional psychiatrists is to train them in civilian teaching institutions, many of which are able and willing to afford an excellent training program for men who have an interest in this specialty and perhaps who have had some little experience therein.

With reference to the securing of civilian psychiatrists on a part-time basis for use in the induction centers, this committee feels that in order to make progress in the matter of securing such services, small working committees to function as on-the-spot processing groups, strategically located, should be appointed by the Association. Such committees might well function in the matter of other projects suggested, such as the rehabilitation of veterans returning to civilian life, the education of industry to the psychiatric viewpoint, the stimulation of interest of social agencies as well as the general public in psychiatric viewpoints, and a more wholesome attitude toward these problems as they affect everyday life.

The matter of rehabilitation of veterans as well as draft rejectees has been suggested as an activity for this committee. Here again we feel small local committees should be organized in order to carry out work of this nature satisfactorily and it does not seem to be a function of this committee except, perhaps, to stimulate interest in the matter.

The Veterans Administration, which has undertaken the important job of rehabilitation, this committee believes is well aware of its responsibilities and our committee wishes that every effort be made to enlarge the scope and improve the quality of work now being done. The task is tremendous but is being energetically attacked within the possibilities of available resources. A resolution from Council addressed to the Veterans Administration, emphasizing this urgent need might be indicated and undoubtedly would prove helpful.

Again this committee must stress the fact that there are only a few techniques which are available for a committee of this kind to utilize—the gathering of information through surveys, carrying out educational campaigns through publication of pamphlets and schedules such as those we employed earlier in our work, and stimulation of interest through the holding of round-tables.

It has been suggested that a survey of a certain area with reference to what happens to the returning veterans be made by this committee. We do not feel that this is feasible unless funds are made available so that a proper group of individuals may be employed in a given community to make such a survey. The experience of one state group in attempting to organize a rehabilitation clinic would indicate that veterans are not inclined to take advantage of such services offered, the reason being that they are far more interested, even at this early date, in finding out their disability status and their rights, than they are in actually receiving help of any sort other than that of a monetary nature. However, if funds are available, it is suggested by this committee that such a survey be made in a representative community.

HARRY A. STECKEL, M. D., *Chairman*,  
THEOPHILE RAPHAEL, M. D.,  
FRANCIS H. SLEEPER, M. D.,  
D. EWEN CAMERON, M. D.,  
WALTER J. OTIS, M. D.,  
HARRY STACK SULLIVAN, M. D.,  
BERNARD T. MCGHIE, M. D.,  
JOHN P. S. CATHCART, M. D.,  
HUGO MELLA, M. D.,  
FRANK F. TALLMAN, M. D.

#### REPORT OF THE COMMITTEE ON PUBLIC EDUCATION

This report of the Committee on Public Education to the Council of The American Psychiatric Association records our efforts in a collective march toward rehabilitation, and follows the principles expressed in the preliminary report of the committee endorsed last December by the Council.

The purpose of the report is two-fold: to clarify in terms of the present and the future the basic functions of this committee; and to give forthwith an account of our stewardship. What have been our policies? How have we directed those policies? What are we undertaking for the future?

The basic concept of rehabilitation as defined by this committee is, we believe, that of psychiatry in general. We believe that rehabilitation cannot be considered in terms of returning service men alone, but that it must be broad enough in scope and purpose to include *all* the people. As we indoctrinated for war, so we must indoctrinate for peace; and as in war, that indoctrination must include preliminary steps in public education to develop healthy attitudes toward returning casualties; to foster a *will-to-do* in peace-time pursuits; and to renew confidence in the future.

With such a background in public education, the real program as we understand it should be formulated around national policies, but should be car-

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ried out through a de-centralized program organized on the community level. It seems reasonable that a federal agency like Veteran's Administration is properly to be entrusted with matters of hospitalization and adjudication, and the recent accomplishments of that organization in cutting red-tape and facilitating its service may prove an encouraging factor in the total effort. The promise of a stream-lined "Selective Service in reverse" gives hope for procedures designed to return a man to society as promptly and efficiently as he was taken out of society. Recently the press has announced an experiment which is under way at one of the military receiving centers wherein definite measures are being taken to indoctrinate for peacetime civilian pursuits along lines which were suggested by this committee more than a year ago.

Our strongest plea, however, has been for a rehabilitation program, not one under highly centralized government control, but one to be carried out by the people themselves on the community levels. We have maintained that any sound plan will enlist the efforts of a group of Americans representative of our national interests; and that to such a group industry, union labor will send its top-flight men, to work out together through democratic methods the confusing problems confronting us. A program of public education in post-war problems must stress the important rôle which industry will play in the whole plan of rehabilitation. In fact, the entrance of psychiatry into industry some decades ago was in itself a step toward "rehabilitation," and today psychiatric principles are to be found in all sound business philosophy.

However, the period that lies ahead will demand a stronger evaluation of those principles and a more enlightened public attitude regarding them. We will need to stress more positively the fact that a man's basic drives in industry are social and psychological as well as economic; and that each of those drives must be met if success is to come to the employee, to industry, and to the nation at large. Well-adjusted employees pay dividends, and it is not a reflection of the "welfare-aura," but rather plain, common sense, to admit that the worker who is most profitable to himself and to industry is that one who finds in his work a means of self-expression and an outlet for his needs of group relationships.

Today those industrialists who are facing the future realistically are acknowledging the fact that in peace, as in war, *The purpose of industry must become the purpose of the worker*, and that industry must find the way for the peacetime worker to associate himself with the process and to consider himself essential to the total effort.

In the course of the year's work, a member of this committee took the opportunity of visiting one of the great war plants of the nation which employs some 38,000 workers. Certain experiments being carried out there in the field of industrial relations indicate the powerful influence which industry will exert in the job of rehabilitation, and what is more striking, they point toward an acceptance and utilization by industry of those psycho-

logical factors which psychiatry believes will make for a more stable society. Through exciting public interest in these industrial developments, we may help to encourage and facilitate their progress.

These broad concepts and principles in rehabilitation which we are trying to get across to the public include also a consideration of educative ideas, and in this connection we have welcomed the newly awakened public interest in a disciplined education and the resultant trend away from the so-called Progressive ideas. We believe that if discipline was necessary for war-time adjustments, it will be more than ever necessary in peacetime adjustments, which are less regimented and less well-defined and which therefore must rely more heavily on the ability of a democratic people to take responsibility and initiative in action.

Such are the factors that have formed the background of our efforts in interpreting to the public the broader concept of rehabilitation. The year just passed has by no means been an easy one. At first, our efforts to do our part were hindered somewhat by the fact that many agencies trying to handle this problem were folding-up almost as rapidly as they were opening-up. But we did affiliate ourselves, and today we are working with the agencies that up to this moment still exist!

We believe that in some ways real progress has been made. For one thing, we have followed the principle of de-centralization in the appointment of our own state Representatives, thus opening the way for more direct cooperation on the community level. While it is true that such a plan gathers speed more slowly, it promises in the long run to be more effective, and we have not been impatient even when we have seen our representatives being snatched up by the military on one hand, and being so rushed with work on the other that they ran around with their tongues hanging out. This condition has only served to make us a little less aggressive in demanding their time and efforts than is our wont in more normal times!

In spite of all the difficulties, with their fine cooperation, we have gone ahead in the program, and throughout the country, our members have been active. Our Representative in Wisconsin, for instance, has worked successfully in coordinating the efforts of his state groups, and has collected and published pertinent data on the experiences of the Information and Counselling Service at the Milwaukee Induction Center.

Our member in Hawaii has drawn up statistics on rehabilitation work in the Territory of Hawaii, and through untiring efforts has laid the groundwork for united action on the part of the various agencies there.

These are but two examples; others have been going quietly ahead, activating their own state plans through their own initiative, without waiting for all the ideas and inspirations to originate from headquarters. In fact, headquarters is benefiting from the ideas and inspirations that are coming to it from all these various localities; and that is as it should be. It is but one of the good results to come from the de-centralization plan.

We feel that real progress has come from our

liaison work with the Committee for Mental Hygiene in the exchange of source materials and considerations of policies. That organization has gone far in accumulating data which will prove of inestimable value as this program develops, and their releases to the press have served to emphasize the cooperative efforts being made. The effect on the public of this cohesiveness in effort should serve to stimulate confidence in future developments.

This committee served in a modest capacity in facilitating the visits of the British psychiatrists who came to this country during the past year in the interests of general rehabilitation problems. The first of these was Dr. Walter S. McClay, who toured the country early last fall with his film of the Mill Hill Emergency Hospital. In helping to distribute this film, this committee has recognized the need for a similar film showing the work that is being done in this country along the lines of hospitals and rehabilitation. Certainly our work here far exceeds that being done in any other country, and in a way this British film is an indictment of our own failure to make use of this effective means of education of both the profession and the public. We leave it to the Council to decide how much more effective a film showing our own vast psychiatric program would have been.

As regards publicity, the well-known paper shortage has cut down the amount of newspaper space formerly allotted to this organization; yet—without underestimating the power of the press or the value of newspaper publicity—we have come this past year to consider this avenue the least potent and most ephemeral in the dispensing of public information. Personal contacts are always of more lasting influence.

With this in mind, members of this committee have traveled across the country to address large groups of industrialists, educators, and others entrusted with the various problems of rehabilitation; and one member has been appointed to the National Association of Manufacturers, which organization itself sought out our advice and counsel.

It is interesting to consider that not so long ago this committee, in regard to its functions, thought almost wholly in terms of "publicity." But with each year our concept has grown; and we see now that the greatest good and final end of the publicity of this committee seems to be its contribution in the building of good will with those individuals who command the avenues of public information through the press. More and more these persons are turning to psychiatry for accurate information; and we believe that one of the important functions of this committee during the past year has been to give sound facts to these news agencies. We have in a sense performed a sterilization on some bad information which might otherwise have duped a public whose understanding we need increasingly. We have tried in every way to prevent clap-trap and cheap publicity from gaining the attention of the public, but without in any way exercising censorship.

In one respect regarding the press, however, this

committee is glad still to be of service. I refer to our handling of the publicity for the Convention. We are grateful that neither paper shortage nor time shortage has deterred us from fulfilling at least in part our traditional, although no longer our most important responsibility in this regard.

In conclusion, we can profitably remind ourselves that although psychiatry has reached its maturity and no longer needs to fight for recognition, there is still much to be done in public education. But we must not be unduly impatient. Medical surgery, for example, gained its present esteem only after centuries of bitter struggle; whereas, the progress of psychiatry has been faster than that of any of the sciences. There still remains prejudice and ignorance in some quarters; but on the whole we can lay down the "Holy Banner" of our crusade, and direct all our thought and efforts toward the job at hand—the re-building of a sick world. We cannot hope to offer a panacea for the world's ills, but we can dedicate the highest skill of our profession to the coming task, and we can pledge our best efforts toward the creation of a society in which the human personality will have a better chance to flourish.

It is toward such goals that this committee dedicates its future work. With the continued approval of the Council in our program of regional representation—hindered though it has been by the difficulties incident to a war period,—we can hope to go forward in the development of long-range planning that will define rehabilitation in terms of all our people.

Respectfully submitted,

C. CHARLES BURLINGAME, M. D.,  
*Chairman,*

GEORGE S. STEVENSON, M. D.,  
*Vice-Chairman,*

CHARLES A. RYMER, M. D.,  
NEWDIGATE M. OWENSBY, M. D.,  
JOHN D. REICHARD, M. D.,  
HENRY O. COLOMB, M. D.,  
MARTIN H. HOFFMAN, M. D.,  
KNOX H. FINLEY, M. D.,  
FRANK H. LUTON, M. D.,  
HOWARD R. MASTERS, M. D.

#### REPORT OF THE COMMITTEE ON RESEARCH

The Research Committee has busied itself with two matters. In the first place, it has examined many papers which have been submitted for the Devereux School Award in Child Psychiatry. Since all the papers have not yet been evaluated by all the members of the committee, a full report cannot be made at this time, but will be submitted to the Council at its meeting, and the award will be given at the Devereux Luncheon during the session of the Association.

Second, the committee is considering two propositions to put before The American Psychiatric Association in regard to research in mental diseases. Whether one or both of these propositions will be submitted to the Council and the Association will depend upon a vote of the committee when it meets just prior to the Council meeting.

These two propositions are the following:

(1) It has been stated that mental disease has become greatly lessened in Soviet Russia and that there are no neuroses in the Russian military forces. To determine whether or not these statements are true seems to be of the utmost importance. The committee therefore proposes that some psychiatrist, well acquainted with the Russian language and with the Russian people, be selected to visit Russia, after official preparations are made, to study, if proper provision can be made, the status of psychiatry and the incidence of psychiatric diseases in the civilian population and the military forces. It is fully realized that there may be insuperable difficulties, but the matter is of paramount importance and it is the duty of The American Psychiatric Association to investigate the situation.

(2) The alternative project is that The American Psychiatric Association signalize its 100th Anniversary by subsidizing financially a Research Council which shall employ a part-time psychiatrist and an efficient secretary to develop a sensory and motor system in relationship to psychiatric research in the United States. On the sensory side, this Council shall study not only the literature in psychiatry, but in the fields of pharmacology, internal medicine and physiology, and acquaint, on the motor side, research with information which may seem relevant to psychiatry. Thus, new drugs are continually appearing. Their value for psychiatry is not known, but their value should be known, and it may save years of delay if an alert Council acquaints research groups with the fact that a promising drug has appeared. Similarly, new techniques for investigating neuro-chemical activity appear in the journals not devoted to psychiatry. These techniques can be, so to speak, seized upon and transmitted to research workers in the field of psychiatry for utilization.

The project would involve the expenditure of a reasonable sum of money per annum. The committee has not finally met to determine what amount of money should be asked for, but it will do so in time to present the program to the Council.

ABRAHAM MYERSON, M. D.,  
Chairman,  
ANDREW J. AKELAITIS, M. D.,  
DAVID C. WILSON, M. D.,  
WALTER L. BRUETSCH, M. D.,  
S. BERNARD WORTIS, M. D.

#### REPORT OF THE COMMITTEE ON LEGAL ASPECTS OF PSYCHIATRY

Your chairman has been completely absorbed with military activities since the first of January, 1944. Committee activities have necessarily been limited for that reason. In order to obtain reactions of committee members to matters of primary interest in legal psychiatry they were asked to comment on the following five subjects:—

- (1) Need for uniformity of commitment procedures
- (2) Question of responsibility for criminal activity

- (3) Extension of teaching of legal psychiatry in medical and law colleges
- (4) Treatment of legal offenders in the armed forces
- (5) Juvenile delinquency

They were requested to report significant new developments occurring in their communities known to have bearing on the field of legal psychiatry. Evaluation of their responses follows. In the main these centered about the question of responsibility for criminal activity, and the extension of teaching of legal psychiatry in medical and law colleges. Abstracts of their suggestions are listed below.

(1) Rules of conduct for application in expert testimony. It is suggested these be prepared by a joint committee of representatives from the American Bar Association and this committee. These rules of conduct aim to replace the so-called "battle of experts" with a procedure which will free the witness from being a participant of either side, and permit him to serve as a scientist rather than as a partisan.

(2) The drawing up of a curriculum for instruction in legal psychiatry in the colleges of medicine and law with special instruction in the field of psychiatric criminology.

(3) Armed forces experiences with offenders against the military law point to immaturity among the offenders. A program which will hasten the process of maturing at the high school age level and earlier in youth is greatly to be desired. This necessitates a program of education for the understanding and needs of the democracy. Repeated emphasis from the members of the committee in both civilian and military life is proof of the seriousness of the problem and the great need to meet it.

(4) Committee members suggest that offenders with abnormal personalities be committed to institutions for confinement for an indeterminate period of time, and decry the frequently repeated short jail sentences usually given to these offenders.

(5) The recognized increase of juvenile delinquency points to the need for closer attention to this problem especially in war time. It is suggested that all juveniles be registered by their finger prints. Attention is called to the fact that there is already a collection of finger prints of eighty million American citizens in the office of the Federal Bureau of Investigation.

(6) Reference is made to the fact that in most state hospitals caring for the mentally ill voluntary admissions are discouraged. This is due in large part to the limited bed capacity and results in giving preference to committed insane patients. This policy interferes with the best mental hygiene practices and should be discontinued. A solution of this problem lies somewhere between the points of increased bed capacity and improved therapy with discharge of patients.

This committee has cooperated with the officers of the section on forensic psychiatry in the selection of papers for the program of this annual meeting. The paper on "Current Problems In Medical And Legal Testimony" by Gustav Bychowski and Frank

J. Curran, chairman of the section, has a direct bearing on one of the problems of primary interest to the committee. A special round-table symposium dealing with the Youth Correction Authority and Psychiatry has been arranged by one of the members of the section, Philip Q. Roche. Interested members of the Philadelphia Bar Association have been invited to participate in this symposium, which deals primarily with the problem of juvenile delinquency.

Your chairman has called a meeting of the members of his committee attending the annual meeting of the association this week. There will be a discussion of "Rules Of Conduct For Expert Witnesses In Criminal Hearings In Which The Question of Responsibility Is Raised." Certain interested and active members of the Philadelphia Bar Association and the president of the American Bar Association have been invited. This invitation is extended to these gentlemen on the recommendation of the Sub-Committee on Legal Psychiatry of the American Bar Association.

Respectfully submitted

PAUL L. SCHROEDER, M. D., *Chairman*

May 14, 1944

#### REPORT OF THE COMMITTEE ON PROGRAM

In organizing the program for the 1944 meeting, the committee was faced with a number of problems, most of which arose out of the unusual character of this meeting. It was desirable to plan the whole program in close relationship to the special features that were being arranged for the observance of the 100th Anniversary of the Association. At the same time, we had to keep in mind wartime conditions and needs, both in regard to the allocation and choice of the material. From a technical point of view the most important problem was the element of time, since the meeting was scheduled to last only four days and within that period of time prominent place was to be occupied by the centennial functions and military psychiatry. The centennial celebration was, of course, considered as a function in which the Society should participate as a unit and because of that, both the Program Committee and the special Centenary Committee decided to set aside for this purpose, a whole day for general sessions. In the other three days it was thought advisable to allocate as much time as possible to military psychiatry and subjects allied to it. Three half day sessions were given over to programs sponsored by the army, navy and public health services. In addition to that, we gave preference to papers dealing with military psychiatry throughout the rest of the program. As a result, such problems as are involved in rehabilitation, psychiatric screening, rejectees, wartime morale, and similar subjects are prominently featured throughout the program. This made it necessary to curtail the time that could be allotted to other presentations dealing with general psychiatric problems or with subjects in allied fields. This resulted in the fact that a number of excellent papers that were sent in for presentation had to be refused or

postponed for later consideration. Furthermore, the time allotted to other papers had to be shortened so as to fit into the program without interfering with the presentation of special features. Thus, for instance, some papers were allowed only 15 minutes each, whereas all the papers dealing with "Convulsive shock therapy" and "Insulin treatment" were restricted to 10 minutes each. In order to save time we placed the discussions of some of these groups of papers at the end of each session, particularly where each session dealt with some specific subject. Finally, the meetings of the four special Sections which on previous occasions had been given two half days each, were restricted to one half day, all of them being placed on Monday afternoon.

It was gratifying to find that with few exceptions, both individual authors and Section groups were quite ready to appreciate the difficulties under which we were working, and arranged their programs in such a way as to present the most important papers in the shortest possible time. Obviously one cannot draw general conclusions in regard to future meetings from the experience this year, because of its unique character. It is possible, however, that some of these changes that we were forced to make because of the needs this year, may well work out to be acceptable even in future meetings.

Aside from the specific problems arising this year, there were others which were not particularly peculiar to this meeting and which we think should be seriously considered by the Council and, in some cases, action taken to obviate similar problems in the future. The first of these is one which has been a cause of worry to the committee for a long time. It is the question of the deadline for sending in papers for presentation before the mid-December meeting of the Program Committee. It is surprising to find that although this custom has been in function for a number of years, a great many of the members either don't know it or, if they do, they don't take it seriously. The committee meets in mid-December to decide on the selection of papers. Usually by that time we have had enough of requests for presentations to be able to make up practically the entire program. Actually, this is the only time when the committee meets as a whole and can decide on the suitability of the papers and the general arrangement of the program. This year, the Chairman of the committee has been getting requests for presentations of papers up until about a month before the meeting. They come, not only from new members, but even from some of the older ones and it makes it especially difficult to get the program ready for publication with these new contributions trickling in months after the program has been completed. Just what one can do to obviate this is a problem which we would like to place before the Council. In the September issue of the JOURNAL each year, a notice appears which states definitely the time when these papers should be sent in, also that these papers need not be completed at that time, as long as an adequate preliminary statement can be given to the committee which will enable it to decide whether

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the paper will fit into the general plan for the program. It would appear that this notice does not have the desirable effects upon most of the members. One wonders whether a statement by the Council, prominently displayed in the JOURNAL so that it would attract more attention, would be of help. Perhaps it might even be well for a definite statement to be made at the meeting itself, at one of the general sessions. Another alternative might be to shift the time of the committee meeting to a later date. A number of scientific societies do not decide on their final program until about a month or six weeks before the meeting takes place. What difficulties this would introduce in the printing of the program is something that the Executive Secretary will probably be well aware of. It is a problem, however, which involves not only unpleasant reactions on part of the members whose papers have to be refused, but quite frequently excludes from the program papers which would really be worth while.

Another problem which came up this year and caused some difficulties that were reported on at the mid-December meeting of the Council, is the question of joint sessions with allied scientific societies. The matter was fully discussed then and there is no need to reiterate it here, but in arranging the program it would be very helpful if the attitude taken by the Council on this matter were more widely and more definitely known.

The plan that has been followed for several years of selecting papers dealing with certain topics and presenting them at special sessions has been further extended this year. In all the sessions but one the papers are grouped around a central theme depending upon the subject matter. To the committee it seemed that this would help to sustain interest and would obviate the need of moving from one session to another in following up papers on some particular subject. If this works out to the satisfaction of the Council and the Society as a whole, it might be well to consider following this plan in future meetings.

We assume that there will be a separate report on the functions of the Centenary Committee and that the special features to be presented on Wednesday will be discussed by the Chairman of the committee. We do wish, however, to express our deep appreciation of the help that Dr. Bond has given us, not only in taking charge of the centenary day functions, but also actively participating in the formulation and arrangement of the rest of the program.

WILLIAM MALAMUD, *Chairman*,  
M. H. ERICKSON,  
G. E. REED,  
H. K. PETRY,  
O. J. RAEDER,  
P. R. LEHRMAN,  
H. MELLA,  
T. A. WATTERS,  
R. W. HALL,  
G. K. COLLIER,  
F. J. CURRAN,  
E. D. BOND.

#### MINUTES OF ROUND TABLES DISCUSSION

##### PSYCHIATRIC NURSING: PAST, PRESENT, AND FUTURE

Dr. Charles P. Fitzpatrick, chairman of the Committee on Psychiatric Nursing, presided.

Dr. Ross McC. Chapman, superintendent of the Sheppard and Enoch Pratt Hospital, Towson, Maryland, discussed "The Past of Psychiatric Nursing." He spoke of the founder of modern nursing, Miss Florence Nightingale, who was the first to develop a well rounded philosophy of nursing education. He dwelt on the contribution of The American Psychiatric Association to the art of medicine and nursing. Psychiatry in the early years was absent from the program of the general schools of nursing in this country, but during the past 30 years the picture has changed. Nursing schools are now seeking affiliations with psychiatric hospital schools, since it has been found that students returning from affiliate courses in psychiatry are more mature and sympathetic and more skilful in dealing with patients. The A. P. A. through its nursing committee has endeavored to stimulate the creation of new nursing schools by setting up minimum standards. Difficulties were met in conflicting state requirements. Finally Mrs. Laura W. Fitzsimmons was employed to survey and report on actual conditions in training schools throughout the country. She found urgent need for better attendant instruction, as well as for more and better prepared teachers, supervisors and head nurses. An attendants' manual is in preparation. Great progress has been made during the past 30 years in psychiatric nursing.

Miss Mary E. Corcoran, adviser in psychiatric nursing for the Division of Mental Hygiene, U. S. Public Health Service, Washington, D. C., discussed "The Present of Psychiatric Nursing." She spoke of the influence of the war on psychiatric nursing, hospitals being overcrowded and building projects being interrupted. She spoke of the unhappy conditions existing because of personnel shortage and lack of facilities and accommodation. Miss Corcoran presented a chart showing nursing care in the state hospitals for 1940, indicating the patient load per graduate nurse or attendant, and concluded her remarks by stating that the nurses who have gone into service deserve much credit but also deserving credit are the ones remaining at home.

Miss Elizabeth S. Bixler, chairman, Committee on Mental Hygiene for Psychiatric Nursing, National League of Nursing Education, dean, Yale University, School of Nursing, discussed "The Future of Psychiatric Nursing." Miss Bixler declared that psychiatric nursing affiliations should be made available to every nurse. The psychiatric point of view should run through all teaching and ward work, with more emphasis on preventive aspects of psychiatric nursing. Suggestions were made for increasing facilities for affiliations, installing a nursing consultant in schools of nursing to introduce psychiatric instruction, and educating communities and families in preventive measures. She concluded by saying that psychiatric nursing will

have reached its goal when it is no longer talked about. The ultimate aim is to include it in the basic branches of medicine with medicine, surgery, pediatrics and obstetrics.

The discussion was carried on by Miss Anna K. McGibbon, R. N., director of nursing, Butler Hospital, Providence, R. I.; Dr. Ralph M. Chambers, superintendent of Taunton State Hospital, Taunton, Mass., a member of the Committee on Psychiatric Nursing of the A. P. A.; Major Kathleen H. Atto, U. S. Army Nurses Corps; Miss Gwen H. Andrew, R. N., superintendent of nurses, U. S. Veterans Administration, Washington, D. C.;

and Miss Theresa Muller, of the Catholic University, who spoke of the post-graduate course. Dr. Charles H. Dolloff, superintendent of New Hampshire State Hospital, Concord, N. H., spoke of the need for encouraging basic schools in mental hospitals, and was followed by Dr. Randall R. MacLean, superintendent of Provincial Mental Institutions, Ponoka, Alberta, Canada, and Dr. Marcus A. Curry, superintendent of New Jersey State Hospital, Greystone Park, N. J.

Mrs. Fitzsimmons closed the discussion by stressing the need to extend more knowledge of mental hygiene and psychiatry to lay people.

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## REPORTS OF SPECIAL COMMITTEES

The following reports of Special Committees were presented to the Association and approved by it during the Centenary convention sessions in Philadelphia, Penna., May 15-18, 1944.

### REPORT OF SPECIAL COMMITTEE ON ADMINISTRATION

We meet in the shadow of a great war. All strata of society make their contributions. Sons of the wealthy are among those in the armed forces and the fathers are heavily taxed, not so heavily as our British and Canadian allies, but more heavily than has ever been the case in this country. The middle classes feel their taxes also. Their families are often small, and small size of family may mean that the only son is in the army. Women on in years and by no means strong are trying, sometimes at the expense of their circulatory apparatus, to keep their houses in the spick and span order that was maintained when they could hire help. The poor are doing well financially, but just when they have the money with which to feed and clothe their children as they would wish, the shopkeeper's shelves go bare and money becomes a worry instead of a means to attain better household standards; and their children too are scattered over the face of the earth in combat and service units.

Deaths and injuries that are not lethal are announced in every mail. Official announcements come from the Army, the Navy, the Maritime Commission, the Coast Guard; but injuries and even deaths due to war conditions are not confined to the armed forces. The civilian death rate in New York State has gone up, and pulmonary tuberculosis after a long period of fairly steady decline is again more frequent. The civilian population is making its contribution to the war effort not only by work on the assembly line, but also indirectly by deterioration in the health of some groups. Many physicians over 50 years of age are actually working themselves to death.

The mentally ill are making their contributions to the war effort. Some are voluntary contributions. We have patients who are knitting and printing and sewing for the Red Cross or some other organization that helps the war effort, or doing our hospital work. Such contributions give us much pride.

Alas, there are other contributions—forced contributions, forced not by the will of the administrator nor by the edict of government, but forced by the general situation. The mentally ill in one place and another are less well taken care of, so that more of them who get sick do poorly and perhaps do not even survive. They are suffering more accidents. Hospital men lament this situation and struggle valiantly against it. They have gathered help from previously unexplored resources, have taken added responsibilities on their own shoulders, but with the amount and quality of per-

sonnel available today they are in many instances quite unable to stem the tide. All honor to our colleagues who are administering public mental hospitals in 1944!

Today's troubles are not all new, by any means. Old faults now bring heavy penalties, and the penalties as usual mostly fall on the patients. The present state of affairs brings into glaring light some deficiencies that existed long before the war, by rubbing out some of the good things that served to cover up the deficiencies. We find this situation:

A hospital of less than 1,500 patients, always operated on scant income. The superintendent timid, not able to control some matters in the hospital because the fiscal agent at the capitol has authority over the hospital kitchen. Ward personnel short. Except for a group of religious objectors and their wives, there would be very few people to care for the patients. No occupational therapy because the fiscal supervisor believes that patients should work either on the farm or in the laundry, and refuses funds. Some patients indeed are working on the farm, with little supervision. In rough weather they are not properly clothed for their work. At night every patient has a sheet under him, but some have none over them. Many patients have no night garments. Except in the most agreeable summer weather, clothing is not sufficient to let large numbers of patients go out of doors. Toilets are inadequate. Bad smells meet one in many places.

*We repeat, these deplorable lacks were not caused by the war, they are only exaggerated by it.*

Running a hospital just now is extraordinarily difficult; one need not wait for new and intriguing types of trouble—they come apace. It is, nevertheless, a challenge to the ingenuity of the superintendent and his administrative advisors and is certainly not a one-man job. Superintendents who have developed an organization of responsible divisional heads now find it priceless. Situations without precedent present themselves from day to day, waiting to be evaluated and disposed of with the patience of Job and the wisdom of Moses. Meeting emergencies is the physician's daily task, and as we see how our colleagues in the hospitals meet theirs, our well-grounded admiration of them rises still higher. They even deem this a time to try new procedures on a small scale as opportunity presents. So they prepare for better times to come.

Only fugitive notes are warranted in the rest of the time allotted to this report.

Styles change in words as in clothes. Illinois has rejoined the majority of states and now calls its hospital heads superintendents instead of "managing officers." In the same year, New York leaves the majority and turns its superintendents into "directors."

Two developments in Illinois may be mentioned to illustrate how advances are sometimes made even in difficult periods, and how sometimes an oppor-

tunity can be only partially seized because of temporary handicaps. The huge Department of Public Welfare in that state had drifted along for several decades with only part-time advisory psychiatric officers to counsel the director. Now two officers called a deputy director and a chief medical officer have been created to exercise authority in our field. This is an advance. A new commitment law in Illinois was devised to keep sick people out of jail and court. One humane provision has placed responsibility for transportation of committed patients upon the hospitals, which would send experienced members of their nursing staffs for the new patients instead of leaving them to the sheriffs. But personnel is so short and vehicles so few that contracts have been made with the sheriffs to continue as transportation agents.

We note with regret that the Texas Psychopathic Hospital has been closed. This move in some measure forestalls the effort of public-minded citizens to get a similar institution located near the medical school in Dallas.

A special commission in New York has reported on the care of the mentally ill. We take no time to discuss the background, the bias or any historical flaws in their apportioning of what they consider blame. With many of their goals we are in hearty accord, such as increasing the staff of the Department of Mental Hygiene, seeking more and stronger candidates for competitive positions, making medical posts for chief clinicians very attractive, increasing the numbers of nurses, dietitians, special therapists and social workers, making better provision for tuberculosis patients, improving hospital plants, destroying cumbersome fiscal processes, increasing the number of psychiatric wards in general hospitals, advancing medical education and research. We reserve a measure of skepticism for plans that have already worked badly, such as abandoning experience in mental hospitals as prerequisite to directing a mental hospital, and expecting parents to accept a verdict of unteachable on their defective children.

A good move is sometimes forced by hard necessity. The great shortage of male ward employees has led to the substitution of women in hospitals where it had not always been appreciated how much better most male patients do if there is a woman around. Older persons, such as married couples between 55 and 65 years of age, have been put on ward duty, and three of them have been reported to do better work than two young people. Ward notes have been made by attendants in hospitals that had no such practice. Salary increases have been made in all parts of the country. More attention has been given to the comfort of employees' quarters in places where transportation to the nearest city has become difficult.

Helpful patients have been employed on a status that gives them both recognition and oversight. As attendant-helpers they have dissolved many a worry. Religious objectors have been employed in 36 mental hospitals, 7 training schools and 1 psychiatric service in a general hospital, to the great benefit of the patients. We regret that two hospitals have felt obliged to use convicts as attendants.

Attendant training, in these days, should be modified to fit the abilities of the older employees. Everything should be made as practical as possible by demonstration, lectures and ward instruction. This is no time to be fussy about just how a bed should be made or whether a little dust lies here and there. The direct personal care of patient is a greater issue.

Your committee welcomes an opportunity to repeat certain points that must appear in any adequate program of administration:

1. The first criterion of efficiency in any hospital is its ability to restore its patients to health and home. This is the prime responsibility and reward of all medical practice.
2. We must expand our facilities for work in the community and do for the out-patient quite as much as for the in-patient.
3. Much more research is demanded, not only by the needs of our patients but also by the very fact that we have such masses of clinical material in our care.
4. Teaching programs of many sorts should be instituted and maintained. Have we knowledge? Let it not be hoarded. Others need it quite as much as we.

Respectfully submitted,

WILLIAM D. BRYAN, M. D.,

CHARLES F. READ, M. D.,

SAMUEL W. HAMILTON,

*Chairman.*

#### REPORT OF COMMITTEE ON MENTAL HYGIENE 1944

There is a fairly consistent pattern of evolution of agencies dealing with the personal and social failures of people. The most primitive service is to render the people harmless to society. The mentally ill are restrained from injuring themselves or others, criminals are removed from society, and the poor are fed, clothed and housed. As these failures become the concern of serious minded people, underlying causes are treated: hospitals replace asylums, reformatories replace prisons and rehabilitation replaces alms. As progress is made in the direction of cure, the way is opened to prevention and finally attention is directed toward a positive service wherein the people as a whole are brought to a higher level of satisfying and effective living.

To different professions come different chances to further these steps in mental hygiene.

To the doctor comes the opportunity of sensing the beginnings of mental breakdown expressed through disordered organs or the more direct exposure of his thoughts, feelings and actions and of helping the patient to turn his sensitivities to positive account as a talent rather than to his own misery as a neurosis. Pediatrics forming a partnership with psychiatry, is recognizing that the baby and its mother participate in a process of emotional growth from the moment of birth and are not merely the consumer and producer of food. The practitioner of internal medicine is seeing the stomach and heart and in fact all of the person

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as expressive of attitudes and life experiences, fears and frustrations, using this insight clinically. The public health officer is beginning to look beyond its traditional focus on morbidity and on toward how people live their lives in happiness or misery.

To the nurse, when the frame of the patient is shaken with illness and anxiety distorts his perspective, are revealed the weaknesses upon which disaster may be built, weaknesses that with her gentle touch, her understanding and her support may be succeeded by self-knowledge and strength.

To the clergyman comes the opportunity to enter into and to sense man's efforts to find a pattern and meaning in the world about him and within him; to help him to tie the experiences of life together in a way that strengthens him for and prepares him to get the best out of life and to save him from the expedient of a stunting psychological regimentation as a defense against quandaries. In times of crises to the clergyman comes the opportunity to recognize that people need not all be alike to be sound and serviceable to society and to provide a differential help, to listen and gently to draw clarity and form from within. In the past this has been the distinction of the good religious counselor, achieved largely by long experience. Today it is a part of the design of some theological education. The mental health of tomorrow is conditioned on its recognition as a fundamental. Increasingly theological students are being introduced to life quandaries and breakdowns of people that out of the knowledge and techniques of those concerned with delinquency, poverty and illness may be borrowed those that can be used in pastoral work. A program for the clinical training of such students in hospitals and prisons is a formal adoption of this principle.

To the teacher are given all people twice, as children of parents and as parents of children. His is the delicate task of guiding the child through our cultural heritage, of guiding him by following him, giving the security of constant backing, supporting his faltering step, watching him thread the maze, enjoying the spark of genius in finding new routes and of giving him constantly richer opportunity to test and evolve his abilities. His also the task of helping the parents who are the products of the schools of yesterday. Schools have cooperated magnificently in the neuropsychiatric selection and allocation of men for our armed forces.

To the social worker comes the opportunity to apply on a large scale principles she has drawn from her case-work, to give to groups of people the chances for self-understanding and growth that are so superior to the traditional processes of legislation and control from the outside.

And then mental hygiene comes to the great field of industry. It has gone beyond occupational therapy to consider the kind of job that challenges without discouraging, that gives security without palling, that allows growth, that can be adjusted to mental and physical handicaps. Mental hygiene sees the danger in leveling work instead of diversifying it. Significant is the adoption of vocational rehabilitation in 1943 as a Federal-State responsi-

bility including service to the mentally handicapped—civilian as well as soldier, recognizing that psychological disabilities also exist in all the physically handicapped.

The American Psychiatric Association endorses the principle that the frontier of mental health is occupied by those who influence the daily living of people.

ARTHUR H. RUGGLES, M. D.,  
GEORGE H. PRESTON, M. D.,  
GEORGE S. STEVENSON, M. D.,  
*Chairman.*

#### PSYCHOANALYSIS

Psychoanalysis began as a treatment technique, discovered almost accidentally. In the course of using it as a treatment technique, Freud discovered that it was likewise a tool of investigation. With the use of this new tool of investigation an entire new world of psychological facts and functions was discovered and explored. From these discoveries a new department of psychology was erected and older psychological (and psychiatric) theories were radically revised so that a new psychology and a new psychiatry emerged.

In the fifty years that have passed since Freud's first published reports of his discoveries, psychoanalysis as a tool of investigation has not been radically altered, but it has been intensively and extensively used. The explorations made possible by it have been pushed by many workers. The developments of psychoanalytic psychology and the new psychoanalytically oriented psychiatry have been expanded. Psychoanalysis as a treatment method has been brought to the status of a generally recognized and accredited modality for the reconstructive therapeutic management of patients with certain types of illness, including not only illnesses representing acute reactions to conflict but illnesses representing personality deformity of long standing.

At the present time psychoanalysis as a body of knowledge is incompletely absorbed by the psychological and psychiatric societies pre-existing. Psychoanalytic insight has transformed in many respects our understanding of psychotic and neurotic conditions, yet we have tried to continue in the main the use of outmoded nosological systems. It is high time that we have the courage of our convictions and discard oldfashioned, outworn diagnostic categories in favor of concepts which are more dynamic and more closely related to the *object* of all diagnosis, namely treatment. This would be a contribution to psychiatry which would be no less fundamental and no less practical than the contributions we can make to assisting in the facilitation of non-psychoanalytic psychotherapy and other recent trends. Similarly it would be a contribution to psychosomatic medicine which, while less dramatic than the dispelling of symptoms and the curing of individual cases by painstaking techniques of various kinds, would tend to align us more usefully with the medical profession generally, and to correlate our vision and experience with theirs.

The principles of psychoanalytic treatment as such remain much in their original form. Attempts to shorten the duration of treatment have been specially stimulated by the present emergency. Analysis of the ego and measures to strengthen the ego have for several years received increasing psychoanalytic attention. Meanwhile psychoanalysis has done much to improve the efficacy of other types of psychotherapy long used empirically by practicing psychiatrists.

But important as it is for us to evaluate the contribution of our specialized techniques to the suffering individuals that file through our consultation rooms, it is infinitely more important to offer what we can to those far more numerous sufferers who are either not sick enough or not fortunate enough to be able to consult us. To these we owe it and also to those who cannot consult us because they are too young or perhaps not yet even born. For them the implications of psychoanalytic theory are more important than the techniques of psychoanalytic practice. Ultimately, education is more important than therapy, not only because it can be applied to more people, but because in effect it is prophylactic. The time will come when the study of prevention will occupy our thoughts more constructively. As the field of child psychiatry is more earnestly cultivated in a spirit of research, the prophylactic implications of accumulated psychoanalytic knowledge will receive more recognition in the curricula of medical education and in the programs of teacher training.

In the main, psychoanalytic education has not yet been satisfactorily established on a university basis. Indeed, general psychiatry as a whole is inadequately presented in most medical schools. The services of numerous psychoanalytically trained psychiatrists in our armed forces have brought increased insight into the practical problems of war psychiatry, as exemplified brilliantly in a number of the papers at this convention. It may be hoped and reasonably expected when the war is over that more adequate means will be developed for the inclusion of such fruitful psychoanalytic insight and knowledge into the education of medical men in general, through the development of better psychoanalytic instruction to medical students, and in post-graduate psychiatric training centers.

Respectfully submitted,

JOHN WHITEHORN, M. D.,  
KARL MENNINGER, M. D.

#### REPORT OF COMMITTEE ON PSYCHOTHERAPY

While some of the medical thinking about psychotherapy can scarcely be generalized, it is clear from the interpersonal standpoint that we are in the midst of a progressive simplification of theoretic formulae and corresponding increasingly precise and definable types of interaction of physician and patient.

Much remains to be observed and formulated; many ill-founded or otherwise unclear ideas need to be dissipated; many a remnant of empirical-dogmatic technique have still to be discarded; but

we already can distinguish some of the major principles that underlie psychotherapy.

1. Psychotherapy is the effecting by principally verbal communication of favorable change in the patient's way of life so that his chances for success and contentment are improved.
2. Psychotherapy is only possible when the patient recognizes (with the physician) a difficulty in living and working with other people, and some possibility of favorable change.
3. Any exchange of intelligence between physician and patient is made possible by, and is strictly dependent on, recognized current needs and foresight. Failures and eccentric results follow advice, persuasion, suggestion and hortatory encouragement which overlooks this principle.
4. While past events, sometimes as remote as early childhood, influence the definition of current situations and the exercise of foresight by the patient, it is what the patient is now and what he can do with the physician that provides the dynamic in psychotherapy.
5. Unless or until he is demoralized or in despair, every patient can manifest persistent striving towards success and contentment. The doctor-patient relationship is unstable and tentative until this tendency has appeared. Thereafter, the relationship is relatively firm and durable, if the physician is diligent and competent to avoid stagnation of therapeutic progress.
6. Intensive psychotherapy rests finally on the professional integrity of the physician. Not the doctor's but the patient's views, needs and prejudices are to be dealt with. Not the doctor's reveries but the patient's performances signify. It is the physician who must always be alert, attentive, aware of what has been happening, and responsible even to the supplying of foresight to prevent impulsive acts which the patient would subsequently regret.

It will be observed that these principles can be related to operational conceptions. Psychotherapy itself, however, does not include teaching any particular theory of personality. The patient improves to the extent that he comes to understand what he is doing and to have insight into his living with others.

A specially rewarding field of psychotherapy is that of child psychiatry. Some very significant technical advances have been made on a basis which have stressed the importance of interrelated participation of parent and child in therapy and finding effective channels of expression for the child. This has emphasized the family unit as the focus of treatment in child psychiatry in contrast to considering the child in isolation.

Parents are no longer considered to be collateral problems to the problem of the child. The child's life situation includes them as the significant figures connected with his experiences of anxiety and the evolution of his self. The family is no longer split up into a group of several at least potential patients. It is handled as a dynamic

entity and treatment is directed toward achieving greater unity and an increasing effectiveness in the interpersonal processes which make up the home life.

In the expanding field of adult therapy the parallel developments may best be considered from the standpoint of prolonged, intensive psychotherapy and other types of intervention. The first of these may perhaps be adequately illustrated by reference to the distributive analysis of Meyer and the organization of techniques which has been developed by the group of workers called The Washington School of Psychiatry.

In distributive analysis, the physician directs the analysis along specific lines selected by him after an evaluation of the inclusive clinical picture, changing them according to the emergence of new facts and possible leads for therapeutic attack. The patient-physician relationship receives constant analytic scrutiny. Attempts at active synthesis accompany analysis. The methods chosen utilize any valid psychotherapeutic procedure, including free association, dream analysis, and hypnosis.

Intensive psychotherapy as taught and practiced in the Washington School was evolved from psychoanalytic study of the psychoses and other relatively severe mental disorders the data from which then underwent critical appraisal in terms of probability and the relevant personal equations, with gradual emergence of the principles above stated.

A strong and commendable interest in "brief psychotherapy" is abroad. In your Committee's judgment, this objective is best sought by way of improved focus and better chosen techniques in psychotherapy unspecified.

It seems that group psychotherapy must be regarded as actually still in the stage of exploratory experiment. Several approaches have shown some promise. Among these are the *psychodrama* of Moreno and others and the significant work being done by psychiatrists in the Army, the Navy, and the Public Health Service.

It is clear that psychotherapy, if it is to meet the needs obvious in our immediate future, must make rapid strides towards far better utilization of each physician's patient-hours. The possible use of therapy aides—physical, chemical, and personal—also demands exploration. This is scarcely to be taken to encourage blind interference, either with human physiology or with social organization, *in lieu* of psychotherapy. Psychotherapy is at best an intensely responsible, most gravely careful, intervention in favor of the patient's approximation to a more adequate general future of humanity.

FREDERICK H. ALLEN,  
OSKAR DIETHELM,  
HARRY STACK SULLIVAN.

#### SHOCK THERAPY

In the short time at our disposal for the presentation of such an extensive field for practice and research as "shock therapy" one can stress only a few selected points pertinent to the topic. A critical review of the literature published on the subject during the past six years would be a major under-

taking; however, those who have kept in relatively close touch with the developments will probably agree to a broad generalization which one may formulate as:

(1) The shock therapies are still under clinical trial and evaluation in public and private hospitals and centers; (2) the extremes of enthusiasm and skepticism regarding the results of these therapies have abated to a certain extent, encouraging a sober scientific attitude in an attempt to determine what it is all about, and (3) that more scientific reporting of results are needed before any sound qualitative and quantitative estimations can be made.

Insulin therapy for the schizophrenic group of disorders has lost much of the interest it commanded originally. However, this type of treatment frequently modifies or eliminates many of the presenting symptoms. In some percentage of patients there is a definite improvement and many workers prefer it to other types of shock. The improvement in undernourished patients is often striking. The use of insulin treatment has declined under war conditions with the shortages in hospital physicians and nurses while the easier applied electroshock therapy has increased notably during this period.

The administration of insulin in sub-coma doses has proved to be a safe and superior method of sedation. It alleviates anxiety and excitement which in turn has a favorable effect upon some of the other psychotic manifestations, causing them to disappear; allowing for a better psychotherapeutic approach to the patient.

Metrazol therapy has suffered a decline in medical popularity, as electric shock is considered to be as effective and less dangerous to use. The survey of over 300 mental hospitals made by Kolb and Vogel, revealed that electroshock therapy had been adopted more rapidly than either of the other methods.

Some of the reasons are: the electroshock method gives little or no discomfort to the patient, requires comparatively little after care; produces amnesia which lessens fear and antagonism to treatment, and it is possible to treat a large number of patients with a minimum of time and personnel.

Convulsive shock therapy is conceded to be an effective method for the treatment of depressions of nearly all types. In the average case of depression it is possible to shorten the period and thus save suffering and time and expense for those patients who must make their own living. Patients in the depressed phases of manic-depressive psychoses can be treated successfully by electroshock in the majority of instances: many reports state a remission rate of 80-90 per cent. In acute manic syndromes the results are said to be about as good; however, the 8-10 treatments usually sufficient for the depressions, are not enough for sustained improvement in manics. Twenty or more convulsions are necessary, according to the experience of some workers. There is apparently no insurance against a recurrence of the disorder, and the reaction types of elation and depression with established cycles, are most difficult to influence.

In the involutional depressions, the results are

usually favorable unless there is a paranoid trend, in which case insulin sometimes works better. In certain profound depressions and agitated depressions of the involutional period, there is not as high a probability of prompt improvement, but whatever favorable results are obtained in this group are more important as otherwise the disorder tends to run a prolonged course. Favorable results are reported for the post-puerperal depressions.

In schizophrenic depressions, improvement is attained as far as the affective disorder is concerned but the schizophrenia itself is not usually completely resolved. Many schizophrenics show improvement in their behavior, with paranoid formulations less active, and social adaptations more satisfactory and in a few of the atypical schizophrenias there is a marked improvement. Psychoneurotics do not generally respond favorably to this treatment.

As yet there is no consensus on the best method of administering convulsive therapy. Some workers advise weekly treatments, some thrice weekly, others daily and still others, more than one treatment per day in selected severe cases. Although it is probable that the main lines of the standard or recommended procedures are followed in most places, the types of patients selected, the number of individual treatments, precautions taken and numerous other details regarded as important by some workers vary greatly. Owing to occasional untoward reaction requiring emergency measures, many experienced workers strongly advise against treating patients outside a hospital.

The mechanism by which the shock treatments produce beneficial effects is not known but with the convulsive types it seems fairly certain that the production of major seizures is necessary. Petit mal seizures have not given satisfactory results. That there are physiological changes produced by the shock therapies is revealed by the alteration in the brain waves, in the conditioned reflexes, in the neurologic phenomena, in the brain metabolism and in the chemical changes in the blood. As far as electroshock therapy is concerned, the alterations in the E.E.G. indicate that there may be, at least, some temporary damage to the intellectual functions. Some of this is reversible and perhaps some is permanent, but as yet no convincing neuropathological evidence of lasting brain damage has been demonstrated. The total number of shocks that may be safely given in relation to permanent damage is not clear.

The contraindications usually emphasized are malignancy, tuberculosis, nephritis, advanced arteriosclerosis, history of coronary disease and severe organic brain disease. Obviously the physical condition of the patient must be evaluated carefully; however, some myocardial damage and arterial hypertension are not always contraindicated to convulsive therapy. Some of these patients emerge improved physically and even patients treated in the period of advanced senility have recovered from an active depression without suffering somatic damage.

The complications of a physical nature which

may attend or follow shock therapy are cardiac failure, circulatory collapse, cerebral vascular accidents, pneumonia, activation of a quiescent tuberculosis, pulmonary abscess, various fractures and dislocations and lame muscles. Respiratory arrest sometimes occurs during convulsive therapy. In the minds of most workers these consequences do not occur with sufficient frequency to warrant discard of the methods, particularly when the contraindications are carefully observed.

While the majority of psychiatrists are of the opinion that a combination of shock therapy and psychotherapy should be utilized, there is no published proof as to the actual value of this combination. It has been recommended by a number of writers that shock therapy should be only a part of a broader therapeutic program which might include active individual psychotherapy, group therapy, recreational therapy and occupational therapy. Additional controlled studies are required on these points before any pronouncement should be made, although it may seem to be a sound common sense procedure.

Concerning discrepancies in the reports of results one would like to know on what basis a choice of patients for treatment was made. Were they selected at random? In order of their admission to the hospital? Because of certain characteristics of their psychosis? With a favorable prognosis in view? Because they had been ill for only a short time, or because they had been sick a long time and every other form of therapy had failed? Moreover, miscellaneous criteria applied to evaluate, and terms used to report the results from different hospitals and workers make it practically impossible to compare findings.

Many believe that the only criterion worthy of consideration is whether the patient is in a condition to leave the hospital and return to the community, and have always reported their results on this basis. There is no question but that these treatments have shortened the period of hospitalization of patients with major psychoses, but enthusiastic physicians and relatives may shorten the period of hospitalization in a large number of patients who are not actually dangerous to themselves or others. One can be quite ill mentally and still remain at home. Therefore, discharges from the hospital as such, are not in the category of scientific criteria.

For future work that will have some scientific significance and thus round out our knowledge of the shock therapies, we suggest that treated patients be classified according to (1) the duration of the disorder, (2) the hereditary and familial load, (3) the characterologic and temperament features, (4) the body type, (5) the previous treatments received, (6) the accurately recorded neurological and psychopathological reactions during the treatment itself, and (7) the psychological characteristics in evidence during the remissions checked carefully by a long period of follow-up work. It is obvious that the failures deserve as much intensive study as the successes, in clinical research.

When all of the present evidence is analyzed in an unprejudiced way, one is justified in recom-

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mending and using shock therapy on carefully selected patients, awaiting in the meantime the much desired and needed additional contributions which will assign it its final place in mental medicine.

Respectfully submitted,

NOLAN D. C. LEWIS, *Chairman*,  
HARRY C. SOLOMON,  
H. E. BENNETT.

#### REPORT OF THE COMMITTEE ON INTERNATIONAL RELATIONSHIPS

Your Committee on International Relationships respectfully submits this summary report of its endeavors from the time of its establishment to the present.

President George H. Stevenson proposed the formation of your committee and President James K. Hall appointed its membership. It has been impracticable to hold meetings of all its members, but its Chairman has been in written communication with its members, with certain past and present officers of the Association, and with others.

The first business of your committee appeared to be the compilation of lists of the names and addresses of psychiatric and related organizations world-wide, and of key persons connected therewith. This was duly accomplished, albeit incompletely. The next step taken was to write letters to all such associations and persons, who appeared to be possibly accessible through the mails, in order to inform them of the objectives of your committee and to solicit their interest, advice and cooperation. The response thereto from within the United States has been satisfying. The paucity of response from elsewhere is disappointing. It seems that some letters failed to reach their destination, that various associations have become inactive, and that key persons have been away from their homes engaged in war activities. Responses received from without this country and Canada were received solely from The National Council for Mental Hygiene, London, England; the Tasmanian Council for Mental Hygiene; The Federal Council of the British Medical Association in Australia; the New Zealand Council for Mental Hygiene; and from Dr. Angel Garma, of Buenos Aires. The failure of more extensive response from the Hispano-American countries is notable. Perhaps the recipients of our letters had vagueness of thought about the practicabilities of both procedure and effect, which in turn led to dilatory attitudes.

It has been gratifying to have the interest and advice of persons representing related activities, such as Prof. Clyde Kluckhohn, Department of Anthropology, Harvard University. Appreciation is directed particularly to certain psychiatrists, for the careful consideration they have given to the problems of your committee and for their advice. They are S. Spafford Ackerly; Franz Alexander; Karl M. Bowman; C. Macfie Campbell; Ross Chapman; R. Finlay Gayle, Jr.; Edwin F. Gildea; James K. Hall; Roy D. Halloran; Samuel W. Hamilton; Karl A. Menninger; Winfred Over-

holser; Arthur H. Ruggles; Harry C. Solomon; Harry A. Steckel; George H. Stevenson; John C. Whitehorn; and Gregory Zilboorg. Several of these persons have indicated their understanding that your committee has attempted, almost desperately, to overcome the difficulties of formulating plans and objectives which should promise practicability and eventual attainment. Your committee regrets its failure to present before this Association a broad and at the same time practicable program. Your Chairman extends his sympathetic appreciation to the other members of your committee for their earnest efforts.

The idealistic implications of Dr. Stevenson's recommendations, which led to the establishment of this committee, are readily apparent. Endeavors in like directions in the past have not been manifestly productive. Advice from many persons has been in the direction of developing practical applications out of Dr. Stevenson's recommendations. It has been hoped that the transmittal of letters to persons and organizations in other countries would promote the closer interrelationship of psychiatrists internationally. Out of such friendly interrelationships it is conceivable that a sound plan of organization could evolve, which should facilitate the effectiveness of the work of your committee. It has nevertheless appeared inevitable that progress can be made but slowly. Dr. Campbell pertinently remarked: "I have an idea that mental hygiene, like charity, begins at home, and that it may be perhaps a little premature to think in broad international terms before one has tackled more immediate national, state, municipal and domestic problems. One has to be a little on one's guard against assuming that psychiatrists have especially well-balanced judgment in regard to human affairs." Like expressions have been received from a number of other clear thinking persons.

It is with all humility that your committee recommends the following practicable endeavors:

(1) That the Association extend an invitation to attend the meetings, to leaders in the psychiatric field in certain selected Central and South American countries. Such invitation should be issued through the appropriate representatives of the United States Department of State (Division of Cultural Relationships).

(2) That the Editors of AMERICAN JOURNAL OF PSYCHIATRY nominate foreign correspondents from several Central and South American countries and sectionally publish in the JOURNAL "Foreign News Letters" pertinent to hemisphere interest in the field of psychiatry.

(3) That the placement be encouraged of carefully selected psychiatrists from various Central and South American countries in psychiatric training in the United States, to the end that they may return home with as much practical knowledge of American psychiatry as we can provide for them within the limits of their visit in this country.

(4) That the Program Committee permit a portion of the program at the annual meeting of the Association in 1945 to be devoted to a group of papers to be presented under the sponsorship of

the Committee on International Relationships. In such proposal it is intended that the number of readers be, at most, five; that the most authoritative readers be obtained; that the content of the papers be well integrated one with another, educative, and as practical as the necessity for theoretical considerations will permit; that the occasion shall not be a "talk-fest" and, to that end, that there shall be no discussion from the floor. Such papers might be presented by an anthropologist, a historian, a sociologist, an economist, and a psychiatrist.

As to the further work of your committee, there seems to be merit in the proposal that discussion meetings be held sectionally, attended by the representatives of various schools of thought. Your committee is professedly humble in its aspirations for accomplishment, but holds the opinion that psy-

chiatrists can make a worthwhile contribution, along with representatives of related endeavors, toward making this a better world in which to live. A recent letter distributed by the American Association for the Advancement of Science contains in its first paragraph the following: "Science has completely changed war. Can it effect equally great changes in times of peace to the advantage of humanity? It undoubtedly can if scientists will cooperate as fully on the problems of peace as they are now cooperating on those of war."

Respectfully submitted:

GLENN MYERS, M. D., *Chairman*,  
CLEMENT C. FRY, M. D.,  
CLARENCE M. HINCKS, M. D.,  
LAWRENCE S. KUBIE, M. D.,  
WILBUR R. MILLER, M. D.,  
WALTER L. TREADWAY, M. D.

## COMMENT

### PSYCHIATRIC NURSING EDUCATION AT YALE

This comment is about three women of whom the medical world has taken note. It relates also to a feature of nursing education at Yale University that deserves bringing into prominence.

It will be recalled that in 1923 the Rockefeller Foundation made an appropriation for a 5-year experiment in nursing education that made possible the establishment of a school of nursing on a parity with the other schools in Yale University. The grant was made with the explicit understanding that theory and practice should be coordinated, and that the course should deal with prevalent diseases, with emphasis throughout on the prevention of illness and the promotion of health.

Miss Annie W. Goodrich was the natural choice for dean of this new school. Miss Goodrich's background is significant. She was the granddaughter of Dr. John S. Butler, superintendent for many years of the Hartford Retreat (now the Institute of Living); she lived in the superintendent's residence where the influence of her grandfather and contact with the life at the Retreat awakened an early interest in the mental side of health and ill health and shaped her attitude to the problems of her later professional career.

When called to Yale she had behind her a long and varied experience as administrator and teacher in schools of nursing, including Teachers College, Columbia University; moreover she had served four years as inspector of schools of nursing in New York State, and six years as director of the Henry Street Visiting Nurse Service of New York City. These two experiences in community service forcibly impressed Miss Goodrich with the limitations of current nursing education. She noted, for example, that in a 1910 sampling of 134 hospitals, 35,000 of the 50,000 beds were in the 15 state hospitals for the mentally ill that were included in the survey; she noted further, that statistics of the Visiting Nurse Service showed a high incidence of tuberculosis among adolescents. These two subjects, mental illness and tuber-

culosis, were rarely included in the student's program of study.

It was most appropriate therefore that Miss Goodrich's original staff should include Miss Effie J. Taylor as professor of nursing education in psychiatry. Thus for the first time in schools of nursing affiliated with general hospitals was a serious deficiency in the curriculum made good and the subject of mental health given the standing and the attention it should have.

Following her retirement, when she became dean emeritus of the Yale School of Nursing, Miss Goodrich returned to the old Hartford Retreat, to the same environment that had colored the first part of her life. There she was named consulting director of nurses in January 1938; there she founded the Postgraduate School of Psychiatric Nursing and was the inspiration of the Annie W. Goodrich Postgraduate Nurses' Association, which now numbers more members than any other graduate school of psychiatric nursing.

Thus throughout her career Miss Goodrich has presented the psychiatric point of view, and she has had the satisfaction of seeing instruction in psychiatric techniques take its proper place as an integral part of the nursing curriculum. Her contribution to nursing education in the United States is a very considerable one.

Among the honors that have come to her are the Distinguished Service Medal awarded to her in the last war; the Medal of the Institute of Social Sciences in 1921; the Medaille d'Honneur de l'Hygiene Publique in 1928; the Walter Burns Sanders Medal in 1932; and the Silver Medal of the Ministry of Social Welfare of France in 1933.

As mentioned above Miss Effie J. Taylor was the first professor of nursing education in psychiatry at Yale, or anywhere for that matter. Born in Canada, now a citizen of the United States, Miss Taylor is a graduate of the Johns Hopkins School of Nursing, and after graduate work at Teachers College she became the first director of the nursing

service of the Phipps Psychiatric Clinic (1911-18). Desiring further experience in social work she served with the Association for Improving the Condition of the Poor in New York City for several years, and in 1923 she accepted the joint position of professor of nursing education in psychiatry, Yale University, and director of the nursing service of the New Haven Hospital. With the cooperation of Dr. Arthur H. Ruggles, superintendent of Butler Hospital, and Miss Anna K. McGibbon, the superintendent of nurses, Miss Taylor was enabled to develop a course that corrected the earlier lack of interest of nurses in psychiatry.

From 1934 to 1944 she held the deanship of the Yale School of Nursing. Of her 21 years work in New Haven Miss Goodrich says: "Too high tribute could not be paid to the strategical ability that successfully overcame the problems involved in the transformation of the traditional concept of nursing education in relation to hospital service into the newer concepts to which this school was committed."

Miss Taylor holds the degree of B. S. from Columbia University and Honorary M. A. from Yale. She has served as executive secretary and president of the National League of Nursing Education. Since 1937 she has been president of the International Council of Nurses. In this capacity she has kept in touch with the membership of the Council throughout the world and has taken steps to insure the effective participation of the nursing forces of the various countries in the postwar reconstruction program. Again in the words of Miss Goodrich: "There are few if any nurses in this or other countries, who could assume with such promise of

success, the burden the presidency of the Council implies today."

Miss Elizabeth S. Bixler assumed the deanship of the Yale School of Nursing July 1, 1944. Her background, like that of Miss Goodrich and Miss Taylor, was psychiatric. Holding the degrees of B.A. (Smith), M.A. (Radcliffe) and B.N. (Yale), she is the first graduate of the school to become dean. Her previous hospital experience is an indication of the quality of her work and likewise of the resources she brings to the highly responsible position she now holds. She has served as supervisor of nursing at the Institute of Human Relations at Yale, as educational director at the Worcester (Mass.) State Hospital, as director of Nursing at the New York Hospital, Westchester Division, and for three years just previous to her return to Yale she was director of nursing at the Norwich (Conn.) State Hospital.

Significantly Miss Goodrich, the first dean, comments on the present one. "The appointment of Elizabeth Seelye Bixler, Yale 1927, as Dean Taylor's successor, brings to the school a nurse who also through a varied experience in the field of psychiatry is convinced of the profound importance of the inclusion of this subject as expressed in theory and practice, *in the curriculum of every school of nursing.*"\*

And so we have the unique record of this exceptional educational center being administered in turn by three leaders in nursing education, each of whom had psychiatric orientation and was disciplined to the psychiatric viewpoint. This circumstance seems worthy of special mention.

\* Italics ours.

#### DELAWARE STATE MEDICAL JOURNAL MENTAL HYGIENE NUMBER

Following an annual custom the June 1944 issue of this journal is given over entirely, under the direction of Dr. M. A. Tarumianz, to psychiatry and mental hygiene. Dr. Tarumianz and his staff at the Delaware State Hospital have contributed all the articles that make up this number. In the leading article Dr. Tarumianz comprehensively surveys post-war demands upon psychiatric services and facilities, and urges early preparation to meet these demands by resuming building operations that had neces-

sarily been suspended, improvement of existing services and expansion of personnel as rapidly as possible, extension of mental hygiene in education and industry.

Particularly in promoting the mental health of its people, Delaware is a very progressive state. The superintendent of the state hospital, Dr. Tarumianz, is also state psychiatrist and an associate editor of the state medical journal. From the hospital as an active center of teaching and influence mental hygiene principles are disseminated,

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public attitudes have been meliorated and legal formalities simplified. One of the most interesting and important contributions has been the inauguration of mental hygiene programs in the schools.

In Delaware conditions appear to have been particularly favorable for development of the psychiatric services. Whatever may be urged against state medicine as exem-

plified in the control of the mental hospitals in certain jurisdictions, assuredly does not apply in the State of Delaware.

Dr. Tarumianz has earned the confidence of public officials, prominent citizens and leaders in business and industry, and of the community, and all these in turn uphold his hands in carrying out the measures of an excellent state program for mental health.

### CUBAN SOCIETY OF NEUROLOGY AND PSYCHIATRY

Announcement of the founding of the Cuban Society of Neurology and Psychiatry has been received from the secretary, Dr. José A. Bustamante. In the names of the president of the new society, Dr. Rodolfo J. Guiral, and of all the members Dr. Bustamante sends cordial and fraternal greetings, to The American Psychiatric Association and to the JOURNAL. "It is our specific purpose," he writes, "to maintain high standards in neurology and psychiatry and to cooperate in the psychiatric activities of our continent, bending our best energies to that end, and hoping that a close relationship may be established between the professional groups of our two countries."

These friendly sentiments of our Cuban colleagues will be heartily reciprocated by the membership of The American Psychia-

tric Association and the readers of the JOURNAL in the United States and Canada.

Rapid and remarkable developments in the field of psychiatry have occurred in recent years in the Ibero-American republics generally, with corresponding expansion of psychiatric literature in Spanish and Portuguese with which it is becoming increasingly important for North American readers to have acquaintance.

The organization of the Cuban Society is one more evidence of the healthy growth of neurology and psychiatry in the Americas; and to its officers and members the JOURNAL extends hearty felicitations and good wishes, as Secretary Overholser has already done on behalf of The American Psychiatric Association.

### SAY IT RIGHT

Ambrose Bierce, the man who vanished, once wrote a very worth while little manual entitled "Write it Right," which fortunately is still in the market, or has been recently and which, through reprinting, should not be permitted like its author to disappear.

But if it is important to write it right, shall we allow that to "say it right" is unimportant? Many will remember the amusing and pertinent remarks made in one of the discussions during the Boston meeting in 1933 by Dr. James V. May, who was president of the Association that year. He contended that while the word "psychiatry" is frequently a stumbling block for the laity, it is not too much to expect that members of our own profession should pronounce it correctly. Dr. May pointed out that the root word "psyche" is pronounced sī'kē, not sicky, and that the same ī sound prevails in

the various derivatives. One says psȳchic, not sickic; psȳchologist, not sickologist; psȳchosis, not sickosis; psȳchopathic, not sickopathic; psȳchomotor, not sickomotor; psȳchogenic, not sickogenic; psȳchometric not sickometric; psȳchoneurosis, not sickoneurosis, etc. Why then the so commonly heard sickiatry, sickiatrist and sickiatric? This lesson in orthoepy we took note of in a brief comment in the July 1933 issue of the JOURNAL. Sad to say, a decade later the lesson is still to learn.

A recent correspondence with Dr. May brought to mind the discussion at that 1933 meeting, and in reply to a reference thereto Dr. May with gentle irony suggested that there should be at least one point on which psychiatrists of all schools could agree, namely the pronunciation of their own name and their own discipline.

## NEWS AND NOTES

**ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE.**—The next annual meeting of this Association will be held at the Hotel Waldorf-Astoria in New York City, December 15 and 16, 1944. The topic will be "Military Neuropsychiatry."

The officers for 1944 are: Colonel Franklin G. Ebaugh, M.C., president; Dr. Harry C. Solomon, first vice-president; Dr. Titus H. Harris, second vice-president; Dr. Thomas E. Bamford, Jr., secretary-treasurer.

**PSYCHIATRIC CLINIC FOR EX-SERVICE MEN, CHICAGO.**—President Ronald P. Boardman of the Illinois Society for Mental Hygiene reports that a clinic for service men discharged for psychiatric disorders has been opened at the former Washington Boulevard Hospital. This clinic, with its staff of psychiatrists, psychologists and psychiatric social workers, will be financed by the Department of Public Welfare and operated as an extension of the Chicago Community Clinic.

It is hoped to open similar clinics in other important sections of the state.

**NEW YORK PSYCHOANALYTIC INSTITUTE.**—At its meeting June 20, 1944, the New York Psychoanalytic Society and Institute elected the following officers:

President: Leonard Blumgart, M.D.  
Vice-President: Sandor Lorand, M.D.  
Secretary: Henry A. Bunker, M.D.  
Treasurer: Z. Rita Parker, M.D.

**INFANTILE PARALYSIS.**—Latest figures from the U. S. Public Health Service, showing state reports through August 5, 1944, reveal a total of 3,992 cases. This is 1,226 cases more than reported for the same period last year when the nation suffered its third worst polio epidemic, and 1,089 cases more than in 1931 when the second worst outbreak was recorded. The records of the worst outbreak in 1916 show there were 6,767 cases by August 1 of that year.

In five states the outbreaks are in epidemic or near-epidemic proportions. They are:

State	Through Aug. 5, 1944	Entire year of 1943
New York .....	902	692
North Carolina .....	470	37
Kentucky .....	377	157
Pennsylvania .....	284	143
Virginia .....	205	61

The serious or threatening outbreaks this summer are confined almost entirely to states east of the Mississippi, while last year's were largely west of the river.

This information is furnished by the National Foundation for Infantile Paralysis, Inc., which has sent epidemic aid into 13 affected states.

**AID TO LIBRARIES IN WAR AREAS.**—Up to the end of 1943, \$160,873.62 has been spent for subscriptions to 325 scholarly and scientific journals, to be stored in this country, for distribution after the war to libraries in war areas. The money is provided by a grant from the Rockefeller Foundation, which has allotted from \$50,000 to \$70,000 annually for this purpose, since 1941. The fund is administered by the Committee on Aid to Libraries in War Areas of the American Library Association, and inquiries should be addressed to Miss Edith A. Wright, Committee on Aid to Libraries in War Areas, Library of Congress Annex, Study 251, Washington, D. C.

Prospective donors are asked to report titles and dates of the journals available to the office of the committee. Shipping instructions will then be issued, indicating where and how shipment should be made.

**PSYCHIATRIC REHABILITATION CLINIC, SAN FRANCISCO.**—The department of psychiatry of the Mount Zion Hospital of San Francisco announces the opening of a psychiatric rehabilitation clinic for the treatment of ex-servicemen and women discharged from the armed forces on account of neuropsychiatric disabilities.

The clinic will be under the direction of Dr. J. Kasanin and will be staffed by psychiatrists, internists, psychiatric social workers, vocational advisers, dieticians, etc. It will be open during the day and in the evening. Close contact will be maintained with the United States army and navy hospitals, the Red Cross, the United States War Manpower Commission, the State Bureau of Vocational Rehabilitation, and the various social agencies of the city.

The project was made possible by a grant from the Columbia Foundation of San Francisco.

**CHILD PSYCHIATRY FELLOWSHIPS.**—The National Committee for Mental Hygiene announces that a limited number of fellowships are being offered for training in extramural child psychiatry. Selection for these fellowships is made by the National Committee, by whom eligible applicants are to be recommended for appointment. The fellows appointed will spend one or two years in a selected clinic, the term and plan of the fellowship to be determined by the peculiar needs of the applicant and his probable future professional activities.

Candidates for fellowship award should have had at least a general internship and two years of psychiatry in an approved mental hospital service, in addition to other qualities fitting them for extramural work. Since this provision of training fellowships comes in response to a definite paucity of personnel in this field, peculiarities of the demand are considered in making appointments. The stipends vary slightly with location and status of the fellow but in general range between \$2000 and \$2400.

Requests for further information and applications should be addressed to Dr. Milton E. Kirkpatrick, The National Committee for Mental Hygiene, 1790 Broadway, New York, N. Y.

**SECOND WARTIME PUBLIC HEALTH CONFERENCE.**—This Conference will be held in the Hotel Pennsylvania, N. Y. C., October 2-5, 1944.

Thirteen organizations will coordinate their own conferences with the 73d annual

business meeting of the American Public Health Association in discussion and evaluation of all phases of public health protection that will have far reaching effects in the post-war world.

New global frontiers in public health will be reported by some of the pioneers who helped establish them. New diseases encountered by American armed forces in various parts of the world, insect problems, control measures against importation of disease by returning veterans, and new disinfectants are among the things that will be discussed.

From the civilian front will come reports on sanitary engineering, laboratory techniques, milk control, dental care, social and industrial hygiene, school health, public health nursing, wartime nutrition, wartime food and drug adulteration, air borne infections, and various diseases.

More than 300 health officials will read papers or participate in panel discussions. The organizations meeting jointly with the American Public Health Association are: American Association of Public Health Dentists, American Film Center, American School Health Association, American Social Hygiene Association, Industrial Nursing Consultants, Municipal Public Health Engineers, Reciprocal Sanitary Milk Control, State and Provincial Public Health Laboratory Directors, State Directors of Public Health Education, State Directors of Public Health Nursing, State Sanitary Engineers, Teachers of Preventive Medicine, National Publicity Council for Health and Welfare Services.

**CHICAGO POSTGRADUATE ASSEMBLY ON NERVOUS AND MENTAL DISEASES, AND WAR.**—A Postgraduate Assembly on Nervous and Mental Diseases, and War, sponsored by the Institute of Medicine of Chicago, will be held on Wednesday and Thursday, November 1 and 2, 1944, in the Palmer House, Chicago, and will be devoted to phases of neurology, psychiatry and neurosurgery that are of particular importance at this time to clinicians, specialists and lay workers in the fields mentioned. There will be a registration fee of \$5.00 for all except those in uniform. Interested physicians and workers in Chicago and the midwest are invited to attend.

There will be five addresses on each of the two mornings and on one afternoon; panel discussions on the afternoon of the second day; a "Neuropsychiatric Information Please" program on the first evening with Dr. Foster Kennedy as moderator; and the 17th Pasteur Lecture of the Institute of Medicine of Chicago on the second evening by Dr. Edward A. Strecker. Among other speakers will be: Dr. Bernard J. Alpers, Dr. C. Charles Burlingame, Capt. Winchell McKendree Craig, Lt. Col. Roy R. Grinker, Dr. Samuel W. Hamilton, Col. William C. Menninger, Dr. Howard C. Naffziger, Dr. Winfred Overholser, Dr. Cobb Pilcher, Lt. Comdr. Howard P. Rome, Dr. Ernest Sachs, Dr. Sidney I. Schwab, Dr. Luther E. Woodward, Dr. Edwin G. Zabriskie.

Complete programs and registration cards can be secured by addressing the Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, Illinois.

**BUTLER HOSPITAL CENTENARY.**—On October 4, 1944, will be held the second and

final centennial celebration to commemorate one hundred years of service of Butler Hospital, not only to its own community and the State of Rhode Island but to the country at large, since the hospital in its long career has received patients from every state in the Union.

This second meeting will be of a lay nature calculated to interest the general public. The hospital will hold "open house" and the public will be invited to inspect various wards and the many shops and therapeutic facilities located on the grounds.

At 8:30 P. M. on October 4 a meeting will be held in the auditorium of the Rhode Island School of Design, to which the public is invited. Governor McGrath and representatives of the medical profession and welfare agencies will speak. The principal address will be made by Colonel H. Edmund Bullis of the U. S. Army, Military Intelligence, on "A Hundred Years of Service in Mental Health." The superintendent, Dr. Ruggles, will discuss "The Past, Present and Future of Rhode Island's Oldest Hospital."

## BOOK REVIEWS

SYNOPSIS OF NEUROPSYCHIATRY. By Lowell S. Selling, M.D. (St. Louis: The C. V. Mosby Co., 1944).

This synopsis (of 500 pages) was written to provide a simple, systematized compendium for the benefit of beginning students, specialists reviewing for examinations, or as a simple source for refreshing perpetually failing memory. The introduction includes definitions, original enough in some ways, but not as accurate as one would desire. As an example, neurology is defined as that "medical specialty having to do with the individual's disability to adjust mechanically to the demands of life." The reader might feel that cardiac decompensation would certainly fall into this category, yet it is not considered primarily a neurological disorder. There are contemporary and practical references to neurological and psychiatric disorders in relation to military service or aviation, but these are not as informative nor as well worked up as they might be.

The embryology of the central nervous system is summarized in one and a half pages, without illustrations, and is of doubtful value. The material on the anatomy of the cerebral structures is not very helpful because there are no diagrams or photographs. Of peripheral nerve lesions, the author makes an attempt to discard the term, polyneuritis, in favor of the more scientifically accurate "neuropathy," which is definitely in keeping with a recent trend; however, he has not been consistent and has used the "itis" in reference to lesions associated with alcohol and the heavy metals. He fails to mention the possibility of the presence of arsenic in the hair and nail-filings of those affected by this element. Disseminated sclerosis is defined as a *chronic inflammatory* disorder characterized by scattered patches of demyelination throughout the central nervous system. Many able workers are not sure about the inflammatory nature of the disorder, and demyelination is a feature more particularly of the early stages. In order to be thoroughly up to date, treatment of multiple sclerosis by anti-coagulants should have been mentioned. In the discussion of glossopharyngeal neuralgia, he states that treatment "is primarily surgical avulsion of the nerve." We wonder what neurosurgeons will think of this! For the treatment of acrodynia a small dose (one-half gram) of luminal is suggested. This is quite a dose for a small child!

The author defines psychiatry as "the medical specialty dealing with the patient's inability to conduct himself in a healthy fashion in his economic, social or cultural life." If this definition were tenable, an individual who had lost money in an unsuccessful business venture might be classed as having a psychiatric disorder. While the author credits Dr. Conally of England as first removing chains from psychiatric patients, the majority of psychiatric historians record that, aside from some

ancients, Philippe Pinel was the first to perform this humane practice. Under the discussion of the conditioned reflex treatment of alcoholism, he suggests that 50 grams of emetine and 55 grams of pilocarpine be administered in one session. These are hazardous doses! Should the delicate conditioned reflex method be taught by a few paragraphs in a compendium? In discussing neurosyphilis he makes the statement that: "Paresis is a lesion due to syphilis affecting the brain and differing from other forms of cerebral syphilis by the fact that its distribution is parenchymatous, that of the others being meningeal, vascular, or interstitial." Physicians seem to have agreed in the past that paresis is a clinical disease entity or syndrome, but in our experience it has not been discussed as a "lesion." The author defines the schizophrenias as follows: "The psychoses in this group represent a complex form of personality deviation, characterized in many cases, by an attempt at flight from an unpleasant reality and a consequent regression to a more infantile level. As the result of inability to adjust to a hostile environment, the patient withdraws to a world of phantasy." In the author's discussion of electric shock treatment for schizophrenics, the statement is made that the treatment is given "two or three times at a sitting." A survey of recent literature on the subject by able workers does not agree with this method, about which he is not very clear. A most valuable treatment for patients with the manic-depressive psychosis is electric shock therapy, which serves to shorten the duration of attack, may prevent exhaustion in the overactive individual, and greatly facilitates and simplifies the burden of care, yet no mention is made of this modern therapy in the disorder for which other workers have found it very valuable. He defines psychoneurosis as "a symptom complex which is caused by mental conflict, exhibits no organic pathology, and manifests itself by disturbances in the thinking process but with little change in the objective behavior of the patient. Most psychoneuroses are relatively benign. Colloquially, the psychoneuroses are termed 'the neuroses' even though there are organic neuroses." Contrary to popular psychiatric opinion, the author discusses "war psychoneuroses" as rather distinct entities and gives "shell shock" as a synonym, which psychiatrists, with good reason, have been trying to avoid since World War I. He devotes much more than the usual allotted space to malingering. Perhaps his work with a court clinic justifies this. In his discussion of hysteria the author states that these syndromes are "of such a nature that they may be produced by an effort of the will." This he follows with the statement that they may be differentiated from malingering by the fact that they "are unconscious in motivation." On traumatic neuroses the author allows himself to indulge in the paradoxical, for he says, "here, *undemonstrable organic changes*

take place even though the neurosis usually follows mild or trifling head injuries." Such contradictions are disconcerting, to say the least! The references consist of three publications, two by the author, and are extremely inadequate for a book venturing to cover so vast a subject. Unfortunately, too many errors, and the loose use of too many words have crept into this synopsis, and the student or specialist seeking short cuts to accurate information would do well to resort to reference books written by masters in their respective fields.

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INTRODUCTION TO THE PSYCHOANALYTIC THEORY OF THE LIBIDO. By *Richard Sterba*. (New York: Nervous and Mental Disease Monographs (No. 68), 1942.)

This little book of 81 pages has a very interesting preface which is obviously motivated by the determination to stem the tide of revolt and the growing tendency towards schisms within the ranks of the psychoanalysts. Alexander being dead, the empire which he conquered is breaking up into provinces headed by captains who now are seeking leadership. This, of course, is what would be expected. The powerful personality of Freud did not brook difference of opinion (witness the secession of Jung and Adler and their excommunication). Now that Freud has gone, the cohesive power of his great energy and glamorous leadership is disappearing. Neo-Freudianism in various forms is rearing its head and to the devoted follower of Freud, such as Sterba, this is anathema and must be dealt with by putting forth as dogma to be accepted the dicta of the departed leader.

The introduction is very curious. It starts off—"Psychoanalysis, successful as a therapy and increasingly accepted by science as it is, has nevertheless to face a real danger nowadays." To the first two parts of this statement very decided exception may be taken. The author states that Freud discovered the instinctual forces, "... the instinctual forces, those gigantic powers discovered by Freud, which operate behind the mental manifestations of mankind." This is too blatant a statement to go unchallenged. The instinctual forces were recognized by any number of philosophers and scientists long before Freud appeared on the scene, even though Freud gave these instinctual forces an immense significance and a curiously transformed appearance.

It would be idle to take up this book in detail and to discuss what seems to me to be the extraordinarily one-sided and consequently erroneous point of view expressed. Recently I reviewed a book entitled, "Autonomic Regulations." This book by Gellhorn is scientific. It cites experiments. It notes the weak places in theory and in knowledge. It passes step by step by experiment and control experiment from one phase of the physiology of the autonomic nervous system to another. It attempts to link together the work done by many workers into a coherent whole, and where failure

to do this is apparent, the author notes the failure and candidly exposes the weakness of his position and of the current knowledge.

Obviously, it would be too much to expect that a book dealing with the psychological phases of the human mind, and especially the instinctual trends of the human being, could be scientific in the sense of experiment and control experiment. It could be scientific, however, in what may be called the manifestation of the scientific spirit: tolerance, candidness, exposition of weakness in the position taken, lack of dogmatism, and the tendency to doubt wherever proof is not adduced. A scientist has a right to build up a hypothesis independent of the facts at hand, but he must be at all times aware of the weakness of his position and be prepared to change gladly and freely as new facts appear.

Nothing of this is evident in this exposition of Freud's doctrines, the word doctrine being used advisedly. There is no evidence that this is all an elaborate hypothesis.

In the discussion of the instinct and, by the way, the emptying of the bladder is called an instinct when as a matter of fact it is fundamentally a reflex, Sterba says, "The aim of the instinct (is) the satisfaction, that is to say, the removal of the condition of excitation at the somatic instinctual source." This brings one to a fundamental fallacy in the whole of Freudian thinking, and that is that the nervous system and psyche both have in general one aim—"to be at peace or to reach the condition of being at peace. The stimuli which flow into it disturb this peace and adequate measures must be taken to remove them, so that the condition of peace may be regained. This recovery of peace is termed restoring control of the stimuli." Actually, the nervous system seeks stimuli, as well as mastering them. It has built up elaborate receptors and, behind these, still more complicated and intricately organized mechanisms for the seeking out of stimuli, for their recognition, for their capture and, in fact, the feeling of excitement which is due to the stimuli as they impinge on a sensitive organism becomes one of the great pleasures of existence. In other words, seeking excitement, seeking stimulation, is as important a phase of nervous and mental activity as the kind of quietude which Sterba and behind him, Freud, calls satisfaction. Satisfaction is much more active than mere peace. It is excitement followed by drive, desire and finally satisfaction. This one-sided concept of the nervous system is responsible for a great many of the errors which have crept into psychoanalysis. It represents one of those mystical and ingenious conclusions which astound the student of Freud. The sensory system leads to memory, the organization of experience, and to action. The result sometimes is peace, but sometimes, too, it is the building up of more desire, more seeking of stimulation, more elaboration of techniques for searching out and developing excitement and stimulation.

We come to another interesting, ingenious, impressive and fallacious conclusion: "Freud has taught us to consider two large groups of instincts

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as fundamentally antagonistic, namely, the instinct of self-preservation and the sexual instinct. Later to some extent, he abandoned this conception of antagonistic instincts," but the author implies that fundamentally it is still sound even though modification has taken place. An example is given of the death of certain insects immediately after they have satisfied the sexual impulse. But obviously this is an isolated phase of sexuality and does not persist in the evolved creature and, as a matter of fact, is present only as an exception rather than the rule. The fact is that sexuality is fundamentally linked up with reproduction, and reproduction is the continuity of the race and is thus not an instrumentation of death, but an instrumentation of continued existence, even though the individual himself sooner or later perishes. In its earlier phases reproduction is not at all associated with death and, in fact, has nothing to do with sex, since it is merely fission or multiplication by division, as it has been paradoxically put. Only in the evolved form does sexuality appear on the scene and then it becomes merely the instrumentation for a different kind of reproduction. It is not necessarily opposed to the instinct of self-preservation, in fact representing the transformation of that instinct into racial continuity.

There is then a clear and complete account of the phases of sexuality following the familiar pattern of its fixation in various levels—oral, anal, etc. A fundamental fallacy in all of the Freudian thinking is the confusion between sensuality and sexuality. Because a child derives pleasure from the sucking of his thumb, this is a sexual manifestation. Because he derives pleasure from something within his mouth, this too is sexuality. If he experiences relief and pleasurable sensation by the movement of his bowels, this is anal sexuality. "Because pleasure-sucking is done rhythmically and most adults' sexual activities show the same rhythm," which they do not, pleasure-sucking becomes sexual.

Pleasure is wider spread than sexuality. It is part of the reward of all instinctual activity and, in fact, of any effort. The mouth seems to be regarded by the Freudians as fundamentally a sexual organ, whereas it is fundamentally an organ for the reception of food; secondarily, it becomes transformed in part into an instrument for sexual pleasure, as in the case of the kiss. It is curious to note that in the recent psychoanalytic literature, the literature of revolt, it seems to have been hailed as a great discovery that the mouth is part of the mechanism of digestion as well as a place where the libido may be fixated at a primitive level, and certainly the rhythm of sucking the thumb has only the grossest resemblance to the rhythm of the sexual act. In the mechanism of Freudian proof any things which resemble one another become identical. So in the famous book on sexuality by Freud the satisfied child, because in some way he resembles the satisfied lover, becomes identical with him, and nutrition and nursing become practically entirely sexual rather than nutritional and sensual. Thus, the author states, "The most important point in common between thumb-sucking and the sexual manifestations of grown-up people, is the unquestionably pleasurable experience of both." But it is entirely arbitrary and a blatant example of *petitio principii* to say that because pleasure is experienced in both that the two are fundamentally the same.

It would be futile and repetitious to go step by step through this exposition of Freud's doctrines challenging and criticizing them. The greatness of Freud is unquestioned, although in the opinion of the reviewer greatness is not synonymous with rightness. It seems to me time that psychiatry reoriented itself away from these doctrines, unproven after fifty years and sought more fertile and more scientific approaches to the problems of psychiatry. What good Freud's ideas brought to us has been assimilated, and Sterba's book, well written and powerfully phrased as it is, memorializes a period in the history of thought which is passing.

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METHODS OF TREATMENT IN POSTENCEPHALITIC  
PARKINSONISM. By *Henry D. von Witzleben*.  
(New York: Grune & Stratton, Inc., 1942.)

von Witzleben compiles for the first time the literature dealing with the therapy of postencephalitic parkinsonism and adds his own observations. The first chapter is devoted to the diagnosis of this condition and especially to the differential diagnosis in the several types of parkinsonism. He emphasizes that postencephalitic parkinsonism is not a sequela but is actually a form of chronic encephalitis.

Under "General Remarks on Treatment" the author deals with the handling of the general physical state of the patients and stresses the advantages derived from a period of hospitalization. von Witzleben reviews the literature on therapy and finds serum, vaccine, fever and intrathecal injections of little or no avail. Of the various forms of chemotherapy only the iodine-vaccineurin method seems to evidence any degree of efficacy. X-ray therapy for adult patients seems contraindicated except as a method to reduce excess salivation by irradiation of the parotid gland. Under "Surgical Therapy" the author presents with very little comment the observations of investigators in this field, and the compilations while extensive are not all inclusive. Under "Treatment with Medicaments" he condemns the use of barbiturates except in cases of epilepsy, and of morphine, while benzedrine he finds to be efficacious in the treatment of oculogyric crises and psychic abnormalities other than severe psychoses. To obtain good results, however, benzedrine must be combined with alkaloids.

von Witzleben then considers the various forms of alkaloid therapy. Nicotine treatment he feels to be of little use and of greater harm. Curare therapy seems of doubtful value in view of side effects produced by the drug. The reported results of bulbocapnine therapy are reviewed. He then discusses treatment with scopolamine, atropine, apatropine, syntropan, harmine, stramonium and the Bulgarian method. The latter, the author is at pains to point out, is not to be confused with the

use of artificial mixtures of alkaloids such as rambellon, but instead consists of the administration of a standardized total extraction of belladonna roots. Bulgarian roots offer substantially better results and paradoxically this is independent of the alkaloid assay, as compared with the assay of roots obtained elsewhere. The preparation the author uses (Bulgakur) contains 0.075 mgm. of total alkaloid per drop. The optimal dosage is a matter of individual variation. The method of dosage is described in detail. While von Witzleben discusses the results of treating 827 cases of postencephalitic parkinsonism by the Bulgarian method the only statistical data he offers are concerned with the patients' work ability after treatment. He finds 71 per cent able to resume their occupation. The Bulgarian method, states von Witzleben, must now be considered the treatment of choice. Atropine therapy the author states to be the second most efficacious. However he presents no statistical data of his own regarding atropine therapy to compare with the results of the Bulgarian treatment and volunteers that his experiences with stramonium cannot be considered extensive. The final chapter is devoted to the use of physical exercises and calisthenic measures. An extensive bibliography dealing with the therapy of postencephalitic parkinsonism completes the volume.

The organization of the book leaves something to be desired in that chapter headings are at times confusing and apparently overlapping. Moreover, subject matter is not always confined to the chapter in which one might reasonably expect to find it, *e. g.*, in the chapter "General Remarks on Treatment" some chemotherapeutic measures are discussed. There are also quite obvious fallacies such as the statement that in cases complicated by anemia liver preparations are of greater value than iron, thus overlooking the quite obvious point of the etiological nature of the anemia. The text is often somewhat vague, as in the discussion of the restriction of the meat in the diet. While von Witzleben appears not at all certain that restriction is indicated as a routine he nevertheless suggests allowing meat twice a week. While he admits the importance of suggestion in evaluating the therapy there is no direct discussion of the importance of psychotherapy in the handling of these patients nor of the necessity of evaluating this factor in the compilation of results from the rigid régime he lays down. However the greatest disadvantage is the failure to provide control material treated with drugs such as stramonium or atropine for comparison with the patients treated by the Bulgarian method, or better still the results of several types of treatment in the same group of patients and by the same observer.

This book is advantageous in that it presents not only a careful résumé of the various procedures used in the treatment of postencephalitic parkinsonism but also because it emphasizes the results of treatment by a newer method and the consideration of the patient as an individual therapeutic problem.

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TEXTBOOK OF CLINICAL NEUROLOGY. Fifth edition. By Israel S. Wechsler. (Philadelphia and London: W. B. Saunders and Co., 1943.)

In the fifth edition of this standard textbook of neurology the author has organized, integrated and revised the basic clinical neurological knowledge as it is known today.

It is commendable that the first one hundred pages of this book are devoted to a lucid discussion of the two most important elements of neurology, that is, how to take and interpret a neurological history—how to perform and interpret a neurological examination.

The remainder of the book consists of a clinical discussion of neurological disease entities, and special emphasis is laid on the common neurological disorders.

The autonomic nervous system section is brief, understandable and dependable—a difficult task to say the least.

The chapters on the neuroses and psychotherapy are exceptionally good in presenting contemporary concepts of diagnosis and types of treatment, including an outline of the various methods of psychotherapy.

This edition can be unqualifiably recommended for medical students, budding neurologists and general practitioners.

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PSYCHOSURGERY. By Walter Freeman, M. D., Ph.D., F.A.C.P., and James W. Watts, B. S., M. D., F.A.S.C. with psychometric and personality profile studies by Thelma Hunt, M. D., Ph.D. (Springfield, Ill., and Baltimore: Charles C. Thomas, 1942.)

This scholarly 300-page volume will take its place in the history of neurosurgery and psychiatry as representing pioneer work in a radical departure among the drastic therapies in psychiatry of the second quarter of the twentieth century.

Even for one with little psychiatric training the book is readable and interesting, and for those whose special interest is in the psychiatric field it will present many fresh and original viewpoints.

The introduction gives a satisfactory historical review of the development of prefrontal lobotomy, or more correctly termed leucotomy. The chapters (pp. 20-60) on the anatomy and function of the frontal lobes offer a fair presentation of the subject. Conclusions are arrived at after consideration of experimental work on animals and clinical studies on man. Some 200 pages are then devoted to the authors' experiences with prefrontal lobotomy as a therapeutic measure. Technical procedures are considered; numerous case reports are given in detail; the results of operative treatment in the various psychiatric clinical groups are recorded. A final chapter, "The Frontal Lobes and the Psychoses," is fascinating reading.

Having observed at first hand the work of Freeman and Watts it was decided to select for operation

and study jointly in the research division of the Toronto Psychiatric Hospital and the division of neurosurgery of the Toronto General Hospital a group of institutionalized patients with severe psychoses of long duration and unfavorable outlook. The results have been encouraging and are appended. They agree substantially with the results reported by Freeman and Watts.

RESULTS OF BILATERAL FRONTAL LEUCOTOMIES

July 23, 1941-July 31, 1944

Diagnosis	No. of cases	Average duration of illness	Results *		
			Failures	Improvements	Recoveries
<i>Affective Disorders:</i>					
Manic-depressive (depressed).	2	8½ yrs.	0	0	2
Involutional melancholia ....	9	4½ yrs.	2	2	5
Schizo-affective (depressive features) .....	1	20 yrs.	0	1	0
	—		—	—	—
	12		2	3	7 (59%)
<i>Schizophrenia:</i>					
Catatonic .....	5	5½ yrs.	1	2	2
Paranoid .....	2	5 yrs.	0	1	1
	—		—	—	—
	7		1	3	3 (43%)
	—		—	—	—
Synopsis of results.....	19		3 (16%)	6 (31%)	10 (53%)
Complications—Hypersexuality (mild)—1 female, 3 male.					

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University of Toronto.

\* Recovery—Remaining out of hospital. Improvement—Improved nursing problem.

AN OUTLINE OF NEUROPATHOLOGY. By A. B. Baker, M.D., Ph.D. Third edition, (St. Louis, Mo.: John S. Swift Co., Inc., 1943).

Neuropathology is dealt with in this volume by the method of tabulated notes on the diseases described and the reproduction of a large number of photographs of gross and microscopical specimens.

This method has its limitations in that it tends to stress the author's personal viewpoint without giving due consideration to opposing opinions. The paper used is poor for completely satisfactory reproduction of photographs, but the majority of the pictures illustrate the notes with sufficient clarity. An index helps to offset the unusual order of presentation. A classified set of references is included.

The value of this publication is difficult to assess because it seems to the reviewer that, while its subject matter is too detailed for assimilation by the average medical undergraduate, its style does not permit it to replace a textbook on neuropathology.

The popularity of the "Outline" is shown by its having gone through three editions since 1940.

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DARK LEGEND. A STUDY IN MURDER. By Frederick Wertham, M.D. (New York: Duell, Sloan and Pearce, Inc., 1941.)

The reading of "Dark Legend," a Study in Murder, encourages us to ask again, whether plans made by man, for man, should take into account our knowledge of the nature of man. Striking as it may seem, thoughtful men of the past have believed

that what we call human intelligence is incapable of absolute knowledge, and, oftentimes, that which we are inclined to regard as reality, exists behind appearances. Thus the appearances of things and events are the result of the illusiveness of our sense impressions. Inferences and deductions are drawn from general and special experiences, the values and significances of which may be misinterpreted. The author of "Dark Legend" discusses one type of human reaction illustrative of the latter which he places in the category of "catathymic" thinking.

This latter term is derived from "kata" meaning "according to" and "thymos" meaning "wish or emotional tendency." From this arises the coined expression "Catathymic Crisis," which the author regards as a clinical pattern. He considers it as a "circumscribed mental disorder, psychologically determined, non-hereditary, without physical manifestations, and not necessarily occurring in a psychopathic constitution." "It's central manifestation consists in the development of the idea that a violent act (against another person or against oneself) is the only solution to a profound emotional conflict." "This idea that a violent act must be committed appears as a definite plan accompanied by a tremendous urge to carry it out."

The author traces the clinical development of a "Catathymic Crisis" as follows:

First, an injurious life experience precipitates an unbearable and seemingly unsolved inner situation leading to persistent and increasing emotional tension; the individual holding the outer situation entirely responsible for his inner tension.

Second, his thinking becomes more and more

self-centered and with apparent suddenness a crystallization point is reached wherein the idea that some violent act against another or against himself is the only way out.

Third, after a prolonged inner struggle leading to extreme emotional tension, the violent act is committed or attempted.

Fourth, following immediately, there is almost a complete removal of the preceding tension and with it a superficially normal period of varying length accompanied by a train of thought which makes him still see the need for the violent act.

Fifth, finally an inner equilibrium becomes re-established that leads to insight and the patient realizes the motives for the violent act with which he had credited himself were not the real driving forces and that the act satisfied a deep inner need of which he was then unaware.

The clinical course of a case of "Catathymic Crisis" is illustrated by the case of a 17 year old Italian lad, who murders his mother to avenge his father and who depicts, in the modern role, the Greek legendary figure of "Orestes," who returning from Athens to Mycenae, following the siege of Troy, revenged his father's death by slaying his mother and her paramour.

The author regards his patient's hostility toward the mother as based upon excessive attachment that lead to distortion of the "mother image" so that it became feared and hated. This concept has been called the "Orestes complex," wherein the "father image" is a friendly one and the whole emotional conflict centers around the mother. "The Orestes" and the "Edipus complex" are not mutually exclusive, both being regarded as a variety of the parent complex and neither directly derived from the other.

Post-Homeric writers, from time to time, have built upon the Orestes legend various symbolisms that not only help interpret the history and character of an earlier Greek culture but afford by comparison an explanation for some present day human motives.

There is the danger that the abstract meanings inherent in the Orestes legend may be interpreted in a somewhat narrow fashion or in terms of the absolute. Such legends stand as symbolisms. On reading "Dark Legend" one is reminded of the remark of Santayana, who once wrote, "Mankind is a tribe of animals living by habits and thinking in symbols: and it can never be anything else."

W. L. T.

**PHYSIOLOGY OF THE NERVOUS SYSTEM.** Second edition. By John Farquhar Fulton. (London and New York: Oxford University Press, 1943.)

The second edition of this valuable book acknowledges many new and important neurophysiological contributions which have appeared during the past five years since the publication of the first one.

The biochemical approach to the physiology of the nervous system has been particularly advanced. In fact, in the recent years more evidence has been accumulated that acetylcholine and its enzyme choline esterase must play a much more important rôle

in the neurophysiological mechanisms than was first anticipated ("as the universal synaptic transmitter") even by the most "ardent supporters of chemical transmission." Actually, acetylcholine and choline esterase are not limited to the synapse, but they exist along the entire neuronal surface and they are also essential to the metabolism of all nerve cells. Furthermore, Nachmansohn indicates that "The choline esterase enzyme system is an integral part of the mechanism responsible for the development and propagation of the action potential." Thus Fulton's statement that "The wide differences once believed to exist between the proponents of the electrical, as opposed to chemical transmission of nerve impulses, have largely disappeared."

Many chapters have been revised\* and others largely rewritten in relation to the recent advances made in many directions; among these are contributions of Dusser de Barenne and his co-workers (W. McCulloch, H. Garol, Gerhardt von Bonin), Bailey and Bucy, concerning the interaction of various areas of cerebral cortex and basal ganglia in higher primates; of R. Dow and G. Connor on cerebellar localization; of Clinton Woolsey, W. Marshall, E. Waler, Talmage Peele and T. Rich on parietal and occipital lobes; of Peter Bronk, S. Tower and Hallowell Davis on the isolation of single sensory units under direct observation; of Denny-Brown, D. Lloyd, J. Eccles and associates on the isolation of single peripheral and central motor units; of M. Hines and M. Kennard on the premotor and motor areas of infant monkeys and chimpanzees; of R. Pitts on the respiratory centers; of H. H. Woollard, Graham Weddell, J. L. Yound and P. Weiss on cutaneous receptors and their regeneration.

Chapter XII on "Autonomic Nervous System" is concisely and successfully rewritten and revised by D. Sheehan of New York University.

Chapter XXVI is written by H. S. Lidell of Cornell University. In this chapter, in a condensed review of the existing literature and of his personal findings, the author reviews and discusses very well Pavlov's theories and those of the most recent investigations on conditioned reflexes. Its aim "is to tempt the reader beyond the boundaries of neurophysiology into the field of physiological psychology."

Many bibliographic references mentioned in the previous edition, being superseded by more recent studies, have been omitted.

Fulton's "Physiology of the Nervous System" already widely appreciated, needs no further praise and one might simply mention that this second

\*Chapter V with the assistance of Dr. David P. C. Lloyd.

Chapter XVII with the assistance of Dr. Donald Marquis.

Chapter XIX with the assistance of Dr. T. C. Ruch.

Chapter XXII with the assistance of Dr. Carlyle Jacobsen.

Chapter XXIV with the assistance of Dr. Margaret Kennard.

edition is well up to date with the most recent achievements in the field of neurophysiology.

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MEDICINE AND THE WAR. Edited by *William H. Taliaferro*, (Chicago: University of Chicago Press, 1944.)

This convenient little volume presents a series of ten Walgreen Foundation Lectures, given by members of the faculty of the Division of Biological Sciences of the University of Chicago. Each lecturer has put down, in succinct form, primarily for lay readers, the essential features of his topic as they are related to the various aspects of war—food, chemotherapy, malaria, disease and modern transportation, shock and blood substitutes, aviation medicine, effects of cerebral injuries, psychiatry and chemical warfare. The chapters by Ricketts (aviation medicine), Walker and Halstead (cranial injuries) and Slight (psychiatry) will be of particular interest to readers of this JOURNAL. The entire volume is excellent, and can be read with profit by every thoughtful citizen as a synopsis of what medicine is doing for war—and vice versa!

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HEALTH AND HYGIENE. By *Lloyd Ackerman, Ph. D.* (Lancaster, Pa.: The Jaques Cattell Press, 1943.)

This volume has been written and set up as a text for instruction of university students in the whole field of health and hygiene, "physical, mental, social and spiritual," as is emphasized repeatedly throughout the book. The author has attempted, he says, to provide a book "that will appeal to mature, inquiring minds in all circles: non-scholastic as well as scholastic, lay as well as professional, and legal, political, engineering, social service, journalistic, pedagogical and religious as well as medical." In keeping with its purpose as a textbook for students, very liberal use has been made of definitions, headings and sub-headings.

Statistics of mortality and morbidity; causative agents of disease; evolution, evaluation and importance of health concepts and health practices; infection and immunity; hypersensitiveness; hygiene of the mouth; hygiene of nutrition; hygiene of the emotions and the intellect (attitudes, behaviour patterns, traits, conflicts, frustrations, adjustments etc.); hygiene of mating; venereal diseases, poisons (in which alcohol, nicotine and caffeine are included); cancer and physical hazards are subjects treated from various aspects, historical, anatomical, physiological, pathological, psychological, sociological and/or preventive. The psycho-sociologic aspect is emphasized throughout. This is illustrated in the following paragraphs from the section on the early history and present status of artificial immunization.

"General Psycho-sociologic Considerations. To assume that artificial immunization originated as

a product of scientific research would be erroneous, for many kinds of preventive inoculations were utilized and continue to be utilized by primitive peoples with no scientific background and no scientific affiliations.

"This implies that the psycho-physiologic characteristics of man have repeatedly interacted with his cultural environment and the realities of disease in such a manner as to impel the performance of acts which wittingly or unwittingly have brought the mechanism of artificial immunization into play (see pages 48ff. and 112f.). He has not always understood the nature of the mechanism that he used; nor has he always attempted to attain a state of immunity by acts which were consciously designed for that specific purpose. But in one way or another and at all cultural levels man has derived certain satisfactions—egoistic, altruistic, sadistic, religious, economic, or otherwise—from the practice of artificially inducing a state of disease or of immunity." Whether this be interpreted as indicating a philosophical approach or otherwise will depend on the bent, training and understanding of the reader.

The subject matter is taken for the most part from the extensive bibliographies at the end of each chapter and to which specific reference is made in the text. It would appear, however, that the presentation has been weighted to some extent by the author's own understanding, or possibly prejudice, in spite of a conscious effort to restrain this influence. On page 188, in discussing the diagnosis of typhoid fever, it is stated that "simple diagnostic signs often are lacking, and it is extremely difficult, usually impossible, to find the typhoid bacillus itself in the body of the host or in his feces." The fallacy here will be recognised by any senior medical student, bacteriologist, or competent technician in a diagnostic laboratory. So, too, the assurance (page 181) that, under standard conditions, a single injection of toxoid (diphtheria) when given to persons less than one year old, will immunize 95 per cent of those so treated is hardly warranted by experience. Such discrepancies serve to put the reader on guard against the ready acceptance of other material in the book. In spite of the importance of mental hygiene or the need for it, it is doubtful that the extensive consideration given to it in this book represents good balance or that it makes any significant contribution in this field. Mastication of many of these subjects by the general student will not add to his mental nourishment.

Nevertheless, there is a great deal of value in this volume—well presented historical material, clear exposure of various cults now thriving on our civilization, many reliable scientific observations and, too, much sound commonsense. The undue emphasis on the psychological and sociological aspects will not detract materially from its value, although this emphasis accounts for a large part of the nearly 900 pages. The style throughout is clear and forceful and makes for easy reading. There is evident, too, the desire for truth, and a realization that truth is difficult to find. The extensive bibliographies for each chapter are of very

considerable value to anyone interested or engaged in preventive medicine and hygiene.

A complete index occupies nearly 32 pages. The printing is clear and free from typographical errors, and the set-up, with its definitions, headings, and sub-headings, is typical of a textbook. Publication of the book indicates a waking interest in the subject of hygiene, including mental hygiene.

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THE WAR AND MENTAL HEALTH IN ENGLAND.

By James M. Mackintosh, M. D. (New York: The Commonwealth Fund, 1944.)

Dr. Mackintosh, professor of preventive medicine at the University of Glasgow, is a leading exponent of mental hygiene in Great Britain. This little book of 90 pages consists of short essays "mainly concerned with mental health in England during the successive phases of the second World War." In concise but inclusive statements he summarizes the psychological, social and administrative situation as the tragic years unfolded—the effect on morale of the prewar depression period; the idealism of a peace-loving democratic people that prevented them from reading the handwriting on the wall. In spite of his fulminations, "they did not believe that Hitler could be so foul a monster as to mean what he said." Then came the sense of relief with the knowledge that after fantastic gestures of appeasement war was at length a reality. The effects of the transition from peace to war on soldier and civilian are reviewed—the threats to mental health of occupational dislocation, the dangers and melancholy of the blackout, the horrors of evacuation and the disrupting of families, the inevitable disturbance of the whole pattern of English living.

Vividly "The Lonely Year" (1940-1941) is described, the reaction to air raids, the conditions of living in shelters and rest centers, the remarkable stamina of the people, who in this year braced themselves and made impossible any foreshadowing of defeat. At the same time the lesson is not overlooked that those who bear up under excessive strain when the utmost of their resistance and output is demanded may give way when the tension is relaxed. Postwar psychiatric casualties as well as those of wartime must be prepared for.

Each phase of the war is depicted as reflected in the minds of the British people and as determining their behavior and outlook: the whole discussion resolves itself into a series of pictures of the mind of Britain at war.

In the final chapters, "Mobilization for Peace," Professor Mackintosh points out the shortage of psychiatric facilities hitherto, discusses the agencies arising under stress of war, notably the Mental Health Emergency Committee, and indicates the expansion of all these services and the new directions that must be taken in the coming peace years. He stresses the enlarging part that psychiatric

social workers must take, the importance of a greatly expanded occupational therapy program, the necessity of widely distributed out-patient clinics, the increasing attention to "the mental health aspect of general hospital treatment," involving the "medical reconditioning while the patient is in the hospital" with the "restoration of a disabled worker to full employment in industry" as the goal. "The process is not a simple transfer from the medical services to the industrial; between the two lies a whole range of problems that are essentially psychological."

Almost every question that may arise in the development of a mental health program of national scope is touched upon and illuminated in this compact volume. With regard to professional education in mental health we read that the course in psychiatry should be "a continuing and growing curriculum extended throughout the students' career. . . . One may contemplate that in the medical curriculum of the future there will be five basic subjects: surgery, medicine, obstetrics, psychiatry and preventive medicine—all except obstetrics spread throughout the three clinical years of the undergraduate course."

Concerning "Schools" in psychiatry the author has some pointed words to say:

The delicate issues of psychiatric theory and the conflicting claims of various schools of thought may be allowed to overlay and obscure the simple message of truth which an undiscerning public can understand. Such has been the bane of religious controversy since the beginning of the Christian era. Psychiatry in the present stage of its evolution contains some of the elements of religious intolerance: each school of thought believes that it alone holds the true gospel and that its opponents are not merely in error but in mortal sin. When there are warring sects it is impossible to create a united front unless the differences can be resolved by compromise in the interests of the general public.

Mackintosh's closing emphasis is on education as the crucial means of raising the level of the nation's health, physical and mental. Preoccupied with attempts to relieve disability, the profession has too long neglected the cultivation of positive mental health. "Children will become healthy in mind and body when training for health is woven into the pattern of education and made part of their daily life. Men and women can be healthy if they have been educated to want health passionately enough. . . . The citizen must be made to realize his personal responsibility for healthy living; and responsibilities of this kind will not be accepted until they become absorbed into daily life from infancy onwards as naturally and imperceptibly as the functions of speech and walking and the habits of cleanliness."

C. B. F.